



WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD

124TH SESSION

GENEVA, 19–26 January 2009

**RESOLUTIONS AND DECISIONS
ANNEXES**

GENEVA
2009



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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 124th session of the Executive Board was held at WHO headquarters, Geneva, from 19 to 26 January 2009. The proceedings are issued in two volumes. The present volume contains the resolutions and decisions, and relevant annexes. The summary records of the Board's discussions, list of participants and officers, and details regarding membership of committees, are issued in document EB124/2009/REC/2.

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¹ As adopted by the Board at its first meeting (19 January 2009).

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² See Annex 1.

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RESOLUTIONS

EB124.R1 Appointment of the Regional Director for South-East Asia

The Executive Board,

Considering the provisions of Article 52 of the Constitution of WHO;

Considering the nomination made by the Regional Committee for South-East Asia at its sixty-first session,

1. REAPPOINTS Dr Samlee Plianbangchang as Regional Director for South-East Asia as from 1 March 2009;
2. AUTHORIZES the Director-General to issue a contract to Dr Samlee Plianbangchang for a period of five years from 1 March 2009, subject to the provisions of the Staff Regulations and Staff Rules.

(Second meeting, 20 January 2009)

EB124.R2 Appointment of the Regional Director for the Western Pacific

The Executive Board,

Considering the provisions of Article 52 of the Constitution of WHO;

Considering the nomination made by the Regional Committee for the Western Pacific at its fifty-ninth session,

1. APPOINTS Dr Shin Young-soo as Regional Director for the Western Pacific as from 1 February 2009;
2. AUTHORIZES the Director-General to issue a contract to Dr Shin Young-soo for a period of five years from 1 February 2009, subject to the provisions of the Staff Regulations and Staff Rules;
3. AUTHORIZES the Director-General to amend the conditions of employment of Dr Shin Young-soo as follows: “you will not participate in the United Nations Joint Staff Pension Fund but will instead receive as a monthly supplement the contribution that the Organization would have paid each month to the Pension Fund had you been a participant”.

(Second meeting, 20 January 2009)

EB124.R3 Expression of appreciation to Dr Shigeru Omi

The Executive Board,

Desiring, on the occasion of the retirement of Dr Shigeru Omi as Regional Director for the Western Pacific, to express its appreciation of his services to the World Health Organization;

Mindful of his lifelong devotion to the cause of international health, and recalling especially his 10 years of service as Regional Director for the Western Pacific;

1. EXPRESSES its profound gratitude and appreciation to Dr Shigeru Omi for his invaluable contribution to the work of WHO;
2. ADDRESSES to him on this occasion its sincere good wishes for many further years of service to humanity.

(Second meeting, 20 January 2009)

EB124.R4 The grave health situation caused by Israeli military operations in the occupied Palestinian territory, particularly in the occupied Gaza Strip¹

The Executive Board,

Guided by the principles and objectives of the Charter of the United Nations, the Constitution of WHO, international law and international humanitarian law and the Universal Declaration of Human Rights;

Affirming that all human rights are interdependent and complementary and that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Confirming the applicability of the Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War, of 12 August 1949, to the occupied Palestinian territory;

Referring to the reports and statements issued by the World Health Organization, the International Committee of the Red Cross and the International Federation of Red Cross and Red Crescent Societies, the United Nations Relief and Works Agency, the United Nations Office for the Coordination of Humanitarian Affairs, the United Nations Children's Fund and other international and regional organizations, relating to the deteriorating health and humanitarian situation in the occupied Gaza Strip as a result of Israeli military operations;

Recognizing also that the Israeli blockade imposed on the occupied Gaza Strip and prevention of the passage and delivery of humanitarian supplies of medicines, food and fuel will lead to grave health and humanitarian consequences;

¹ See Annex 7 for the financial and administrative implications for the Secretariat of this resolution.

Expressing its deep concern regarding the consequences of Israeli military operations in the occupied Gaza Strip, which have, thus far, resulted in the killing of more than 1300 persons and injured thousands of Palestinian civilians, more than half of whom are women, children, infants and elderly persons;

Expressing its deep concern about the serious deterioration of the health conditions of all Palestinians in the occupied Palestinian territory and in the Gaza Strip in particular;

Asserting the right of patients as well as Palestinian and other medical personnel to access Palestinian health institutions,

1. WELCOMES and emphasizes the respect of the ceasefire from both parties and calls for a complete withdrawal of Israeli forces from the Gaza Strip, the lifting of the Israeli blockade and opening of all border crossings in order to allow access and free movement of humanitarian aid to the occupied Gaza Strip, including reinforcing of humanitarian corridors to ensure the delivery of humanitarian medical and food aid and to facilitate the passage of medical teams and the transfer of the wounded and injured;
2. STRESSES avoiding targeting of civilians and residential areas from both sides in accordance with the Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War and avoiding targeting of hospitals, clinics, medical centres, ambulance and emergency crews and food and medicine warehouses;
3. CALLS upon providing Palestinian people with the protection to live in security on their land, allowing them free movement and facilitating the tasks of medical teams, ambulances and emergency relief efforts, and enabling them to continue to provide health services;
4. CALLS for the urgent provision of necessary support for the Palestinian people by making available the urgent and immediate needs of ambulances and medical teams, medicines and medical supplies, as well as necessary coordination measures to facilitate the passage of this assistance to the Gaza Strip in support of the health sector and preventing the collapse of health institutions;
5. CALLS for contribution to the reconstruction of the health infrastructure in the Gaza Strip, which has been destroyed by the Israeli military operations;
6. REQUESTS the Director-General to dispatch urgently a specialized health mission to identify the urgent health and humanitarian needs and assess the destruction of medical facilities that has occurred in the occupied Palestinian territory, particularly in the Gaza Strip and to submit a report on current, medium- and long-term needs on the direct and indirect effects on health of the Israeli military operations to the Sixty-second World Health Assembly.

(Fifth meeting, 21 January 2009)

EB124.R5 Climate change and health¹

The Executive Board,

Recalling resolution WHA61.19 on Climate change and health;

Noting the proposed workplan on climate change and health,

1. ENDORSES the proposed workplan on climate change and health;²
2. REQUESTS the Director-General:
 - (1) to implement the actions contained in the workplan on climate change and health;
 - (2) to report annually, beginning in 2010, through the Executive Board, to the Health Assembly on progress in implementing resolution WHA61.19 and the workplan.

(Seventh meeting, 22 January 2009)

EB124.R6 Reducing health inequities through action on the social determinants of health

The Executive Board,

Having considered the report on the Commission on Social Determinants of Health,³

RECOMMENDS to the Sixty-second World Health Assembly the adoption of the following resolution:¹

The Sixty-second World Health Assembly,

Having considered the report on the Commission on Social Determinants of Health;

Noting the 60th anniversary of the establishment of WHO in 1948, and its Constitution, which affirms that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Noting the 30th anniversary of the International Conference on Primary Health Care at Alma-Ata in 1978, which reaffirmed the essential value of equity in health and launched the global strategy of primary health care to achieve health for all;

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

¹ See Annex 7 for the financial and administrative implications for the Secretariat of this resolution.

² See Annex 1.

³ Document EB124/9.

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

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

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

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

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

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

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

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

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

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

1. EXPRESSES its appreciation for the work done by the Commission on Social Determinants of Health;

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

2. CALLS UPON the international community, including United Nations agencies, intergovernmental bodies, civil society and the private sector:

(1) to take note of the final report of the Commission on Social Determinants of Health and its recommendations;¹

(2) to take action in collaboration with WHO's Member States and the WHO Secretariat on assessing the impacts of policies and programmes on health inequities and on addressing the social determinants of health;

(3) to work closely with WHO's Member States and the WHO Secretariat on measures to enhance health equity in all policies in order to improve health for the entire population and reduce inequities;

3. URGES Member States:

(1) to develop and implement goals and strategies to improve public health with a focus on health inequities;

(2) to take into account health equity in all national policies that address social determinants of health and to ensure equitable access to health promotion, disease prevention and health care;

(3) to ensure dialogue and cooperation among relevant sectors with the aim of integrating a consideration of health into relevant public policies;

(4) to increase awareness among public and private health providers on how to take account of social determinants when delivering care to their patients;

(5) to contribute to the improvement of the daily living conditions contributing to health and social well-being across the lifespan by involving all relevant partners, including civil society and the private sector;

(6) to contribute to the empowerment of individuals and groups, especially those who are marginalized, and take steps to improve the societal conditions that affect their health;

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

(8) to develop, make use of, and if necessary, improve health information systems in order to monitor and measure the health of national populations, with data disaggregated according to the major social determinants in each context (such as age, gender, ethnicity, education, employment and socioeconomic status) so that health inequities can be detected and the impact of policies monitored in order to devise appropriate policy interventions to minimize health inequities;

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

4. REQUESTS the Director-General:
- (1) to work closely with partner agencies in the multilateral system on appropriate measures that address the social determinants of health and promote policy coherence in order to minimize health inequities; and to advocate for this topic to be high on global development and research agendas;
 - (2) to strengthen capacity within the Organization with the purpose of giving sufficient priority to relevant tasks related to addressing the social determinants of health in order to reduce health inequities;
 - (3) to implement measures, including objective indicators for the monitoring of social determinants of health, across relevant areas of work and promote addressing social determinants of health to reduce health inequities as an objective of all areas of the Organization's work, especially priority public health programmes;
 - (4) to ensure that ongoing work on the revitalization of primary health care addressing the social determinants of health is aligned with this, as recommended by *The world health report 2008*;
 - (5) to provide support to Member States in implementing a health-in-all-policies approach to tackling inequities in health;
 - (6) to provide support to Member States, upon request, in implementing measures with the aim of integrating a focus on social determinants of health across relevant sectors and in designing, or if necessary redesigning, their health sectors to address this appropriately;
 - (7) to provide support to Member States, upon request, in strengthening existing efforts on measurement and evaluation of the social determinants of health and the causes of health inequities and in developing and monitoring targets on health equity;
 - (8) to support research on effective policies and interventions to improve health by addressing the social determinants of health that also serve to strengthen research capacities and collaborations;
 - (9) to provide support to the regional directors in developing a regional focus on issues related to the social determinants of health and in engaging a broader range of countries in this issue, in accordance with the conditions and challenges of each region;
 - (10) to convene a global event, with the assistance of Member States, before the Sixty-fifth World Health Assembly in order to highlight the developments, progress and renewed plans for addressing the alarming trends of health inequities and to increase global awareness on social determinants of health, including health equity;
 - (11) to report on progress in implementing this resolution to the Sixty-fifth World Health Assembly through the Executive Board.

(Eighth meeting, 23 January 2009)

EB124.R7 Chagas disease: control and elimination

The Executive Board,

Having considered the report on Chagas disease: control and elimination,¹

RECOMMENDS to the Sixty-second World Health Assembly the adoption of the following resolution:²

The Sixty-second World Health Assembly,

Having considered the report on Chagas disease: control and elimination,

Expressing its satisfaction at the considerable progress achieved by countries towards the goal of eliminating Chagas disease by 2010, as recommended in resolution WHA51.14;

Underlining that 2009 will mark the centenary of the description of this disease by Dr Carlos Chagas;

Acknowledging the progress made with vector-control strategies;

Recognizing the success achieved through the intergovernmental initiatives in Latin America;

Taking into account the need for the harmonization of diagnostic and treatment procedures;

Recognizing the need for the provision of adequate care for late severe clinical manifestations;

Underlining the need for more effective, safe and adequate medicines, including paediatric formulations, and for better coverage and distribution of those currently available;

Recognizing that the risk of transmission through blood transfusion and organ transplantation and of congenital transmission is increasing;

Acknowledging the significant collaboration and support among Member States and the support of other partners and appreciating their continuous assistance,

1. URGES Member States:

(1) to reinforce efforts to strengthen and consolidate national control programmes and to establish them where there are none;

¹ Document EB124/17.

² See Annex 7 for the financial and administrative implications for the Secretariat of this resolution.

- (2) to establish mechanisms to ensure broad coverage of adequate control measures, including the promotion of decent and healthy living conditions, prevention and the integration of specific actions within health services based on primary care;
- (3) to harmonize systems and strengthen capacities for surveillance, data collection and analysis and dissemination of information;
- (4) to promote and encourage operational research on control of Chagas diseases in order:
 - (a) to interrupt transmission by domestic insect vectors;
 - (b) to develop more suitable, safer and more affordable medicines;
 - (c) to reduce the risk of late complications of the infection;
 - (d) to establish systems of early detection, in particular for the detection of new infections, of congenital infections in newborns and the reactivation of the disease in immunocompromised patients;
 - (e) to optimize blood transfusion safety and screening procedures in endemic and non-endemic countries with special focus on endemic areas;
- (5) to develop public health measures in endemic and non-endemic countries, with special focus on endemic areas, for the prevention of transmission through blood transfusion and organ transplantation, early diagnosis of congenital transmission and management of cases;

2. REQUESTS the Director-General:

- (1) to draw attention to the burden of Chagas disease and to the need to provide equitable access to medical services for the management and prevention of the disease;
- (2) to strengthen implementation of vector-control activities in order to achieve interruption of transmission and to promote research to improve or develop new prevention strategies;
- (3) to provide support to the countries of the Americas in order to strengthen intergovernmental initiatives and the Pan American Sanitary Bureau as a successful form of technical cooperation among countries;
- (4) to collaborate in order that countries and intergovernmental initiatives set objectives and new goals for the elimination of the transmission of the parasite;
- (5) to support the mobilization of national and international, public and private financial and human resources to ensure achievement of the goals;

- (6) to promote research on elimination of Chagas disease;
- (7) to support efforts at collaboration among multisectoral actors, networking among organizations and other interested parties to support the development and implementation of Chagas disease control programmes;
- (8) to report on progress in the elimination of Chagas disease to future World Health Assemblies.

(Tenth meeting, 24 January 2009)

EB124.R8 Primary health care, including health system strengthening

The Executive Board,

Having considered the report on primary health care, including health system strengthening,¹

RECOMMENDS to the Sixty-second World Health Assembly the adoption of the following resolution:²

The Sixty-second World Health Assembly,

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

Having considered the report on primary health care, including health system strengthening;

Recalling the Declaration of Alma-Ata (1978), the Ottawa Charter for Health Promotion (1986), the United Nations Millennium Declaration (2000) and subsequent relevant resolutions of WHO's regional committees and Health Assemblies;³

Recalling also the discussions at the series of summits and global, regional and national conferences that have reaffirmed the commitment of Member States to primary health care and strengthening health systems;⁴

¹ Document EB124/8.

² See Annex 7 for the financial and administrative implications for the Secretariat of this resolution.

³ Resolutions WHA54.13, WHA56.6, WHA57.19, WHA58.17, WHA58.33, WHA60.22, WHA60.24, WHA60.27, WHA61.17 and WHA61.18.

⁴ Including summits on health system strengthening, such as the G8 Hokkaido Toyako Summit (2008), International Conference on Global Action for Health System Strengthening (Tokyo, 2008), International Conference dedicated to the 30th Anniversary of the Alma-Ata Declaration of WHO/UNICEF on primary health care (Almaty, 2008), and G15 Summit (2004); WHO regional meetings on primary health care, such as those at Buenos Aires (2007), Beijing (2007), Bangkok (2008), Tallinn (2008), Ouagadougou (2008), Jakarta (2008) and Doha (2008); and conferences on health promotion, such as Ottawa (1986), Adelaide (1988), Sundsvall (1991), Jakarta (1997), Mexico City (2000), Bangkok (2005) and the MERCOSUR Task Force on Health (since 1995).

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

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

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

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

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

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

1. URGES Member States:

- (1) to ensure political commitment at all levels to the values and principles of the Declaration of Alma-Ata, keep the issue of strengthening health systems based on the primary health care approach high on the international political agenda, and take advantage, as appropriate, of health-related partnerships and initiatives relating to this issue, particularly to support achievement of the Millennium Development Goals;
- (2) to accelerate action towards universal access to primary health care by developing comprehensive health services and by developing national equitable and sustainable financing mechanisms, mindful of the need to ensure social protection and protect health budgets in the context of the current international financial crisis;
- (3) to put people at the centre of health care by adopting, as appropriate, delivery models focused on the local and district levels that provide comprehensive primary health-care services, including health promotion, disease prevention, curative care and end-of-life services, that are integrated and coordinated according to need;

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

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

(4) to promote active participation by all people, in the processes of developing policy and improving health and health care, in order to support the renewal of primary health care;

(5) to train adequate numbers of health workers, able to work in a multidisciplinary context, in order to respond effectively to people's health needs;

(6) to ensure that vertical programmes, including disease-specific programmes, are developed and implemented in the context of integrated primary health care;

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

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

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

2. REQUESTS the Director-General:

(1) to ensure that WHO reflects the values and principles of the Declaration of Alma-Ata in its work and that the overall organizational efforts across all levels contribute to the renewal of primary health care;

(2) to strengthen the Secretariat's capacities to support Member States in their efforts to deliver on the four broad policy directions for renewal of primary health care identified in *The world health report 2008*;

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

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

(5) to report to the Sixty-third World Health Assembly, and subsequently every two years to the Health Assembly, through the Executive Board, on progress regarding this resolution, including reporting on the effectiveness of WHO in its support to countries in the implementation of primary health care.

(Eleventh meeting, 26 January 2009)

EB124.R9 Traditional medicine

The Executive Board,

RECOMMENDS to the Sixty-second World Health Assembly the adoption of the following resolution:¹

The Sixty-second World Health Assembly,

Having considered the report on primary health care, including health system strengthening;

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

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

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

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

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

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

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

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

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

¹ See Annex 7 for the financial and administrative implications for the Secretariat of this resolution.

² Document WHO/EDM/TRM/2002.

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

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

(1) to consider adopting and implementing the Beijing Declaration on Traditional Medicine in accordance with national capacities, priorities, relevant legislation and circumstances;

(2) to respect, preserve and widely communicate, as appropriate, the knowledge of traditional medicine, treatments and practices, appropriately based on the circumstances in each country, and on evidence of safety, efficacy and quality;

(3) to formulate national policies, regulations and standards, as part of comprehensive national health systems, to promote appropriate, safe and effective use of traditional medicine;

(4) to consider, where appropriate, including traditional medicine into their national health systems based on national capacities, priorities, relevant legislation and circumstances, and on evidence of safety, efficacy and quality;

(5) to further develop traditional medicine based on research and innovation, giving due consideration to the specific actions related to traditional medicine in the implementation of the Global strategy and plan of action on public health, innovation and intellectual property;

(6) to consider, where appropriate, establishing systems for the qualification, accreditation or licensing of traditional medicine practitioners and to assist traditional medicine practitioners to upgrade their knowledge and skill in collaboration with relevant health providers;

(7) to consider strengthening communication between conventional and traditional medicine providers and, where appropriate, establishing appropriate training programmes for health professionals, medical students and relevant researchers;

(8) to cooperate with each other in sharing knowledge and practices of traditional medicine and exchanging training programmes on traditional medicine, consistent with national legislation and relevant international obligations;

2. REQUESTS the Director-General:

(1) to provide support to Member States, as appropriate and upon request, in implementing the Beijing Declaration on Traditional Medicine;

(2) to update the WHO traditional medicine strategy 2002–2005, based on countries' progress and current new challenges in the field of traditional medicine;

(3) to give due consideration to the specific actions related to traditional medicine in the implementation of the Global strategy and plan of action on public health, innovation and intellectual property;

- (4) to continue providing policy guidance to countries on how to integrate traditional medicine into health systems, especially to promote, where appropriate, the use of traditional/indigenous medicine for primary health care, in line with evidence of safety, efficacy and quality;
- (5) to continue providing technical guidance to support countries in ensuring the safety, efficacy and quality of traditional medicine;
- (6) to strengthen cooperation with WHO collaborating centres, research institutions and nongovernmental organizations in order to share evidence-based information and to support training programmes for national capacity building in the field of traditional medicine.

(Eleventh meeting, 26 January 2009)

EB124.R10 Amendments to the Financial Regulations and Financial Rules¹

The Executive Board,

Having considered the report on amendments to the Financial Regulations and Financial Rules, relating in particular to the introduction of International Public Sector Accounting Standards,²

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

1. CONFIRMS, in accordance with Financial Regulation 16.3, the revised Financial Rules as shown in Annex 2 of the report on amendments to the Financial Regulations and Financial Rules,² provided that the amendments proposed to the Financial Regulations as set forth in Annex 1 of the report have been adopted by the Health Assembly, to be effective as from 1 January 2010;
2. RECOMMENDS to the Sixty-second World Health Assembly the adoption of the following resolution:³

The Sixty-second World Health Assembly,

Having considered the report on amendments to the Financial Regulations and Financial Rules,

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

1. ADOPTS the changes to the Financial Regulations as shown in Annex 1 of the report on amendments to the Financial Regulations and Financial Rules,² to be effective as from 1 January 2010;

¹ See Annex 2.

² Document EB124/22.

³ See Annex 7 for the financial and administrative implications for the Secretariat of this resolution.

2. NOTES that the changes to the Financial Rules as confirmed by the Executive Board at its 124th session shall be effective at the same time as the amendments to the Financial Regulations adopted in paragraph 1;

3. AUTHORIZES the Director-General to number the revised Financial Regulations and Financial Rules appropriately.

(Eleventh meeting, 26 January 2009)

EB124.R11 Relations with nongovernmental organizations¹

The Executive Board,

Having examined the report of its Standing Committee on Nongovernmental Organizations,²

1. DECIDES to admit into official relations with WHO the International Medical Corps;
2. CONFIRMS, in accordance with decision EB120(3), the status of provisional official relations with WHO, solely for the purpose of participating in the work of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property, of the following nongovernmental organizations: International AIDS Vaccine Initiative; The Global Alliance for TB Drug Development, Inc.; Africa Fighting Malaria International, Inc.; and Eucomed;
3. NOTES that the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property has completed its work and, therefore, no further action is required with respect to the provisional official relations status of the nongovernmental organizations listed in paragraph 2 of this resolution;
4. NOTES that, in addition to its admission into provisional official relations with WHO solely for the purpose of participating in the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property, Eucomed has requested admission into official relations with WHO;
5. DECIDES, in the absence of an agreed workplan, to postpone the consideration of the application of Eucomed for admission into official relations with WHO;
6. DECIDES to discontinue official relations with the Inter-American Association of Sanitary and Environmental Engineering and the International Association of Human–Animal Interaction Organizations.

(Eleventh meeting, 26 January 2009)

¹ See Annex 3, and Annex 7 for the financial and administrative implications for the Secretariat of this resolution.

² Document EB124/25.

EB124.R12 WHO's role and responsibilities in health research¹

The Executive Board,

Having considered the draft of the WHO strategy on research for health,²

RECOMMENDS to the Sixty-second World Health Assembly the adoption of the following resolution:³

The Sixty-second World Health Assembly,

Recalling resolution WHA58.34 on the Ministerial Summit on Health Research and resolution WHA60.15 on WHO's role and responsibilities in health research;

Recognizing the contribution of research to the development of solutions to health problems and the advancement of health worldwide;

Aware that, in a rapidly changing world facing significant environmental, demographic, social and economic challenges, research will be increasingly essential for clarifying the nature and scope of health problems, and for identifying effective life-saving interventions and strategies;

Realizing the increasingly multidisciplinary and intersectoral nature of research for health improvement;

Affirming the roles and responsibilities of WHO, as the leading global health organization, in health research;

Recognizing the need to strengthen the capacity of the public sector in health research;

Acknowledging that research activities in the private and public sectors can be mutually supportive and complementary in improving health globally;

Conscious of the need to strengthen the conduct, management and coordination of WHO's activities in health research;

Cognizant of the need to better communicate WHO's research activities and results, especially to its Member States and partners;

Noting the references to research for health in resolution WHA61.21 on the Global strategy and plan of action on public health, innovation and intellectual property and relevant conclusions and recommendations of the WHO Commission on Social Determinants for Health;

Taking into account the outcomes of the Global Ministerial Forum on Research for Health (Bamako, 17–19 November 2008),

¹ See Annex 4.

² Document EB124/12.

³ See Annex 7 for the financial and administrative implications for the Secretariat of this resolution.

1. ENDORSES the WHO strategy on research for health;¹
2. URGES Member States:
 - (1) to recognize the importance of research for improving health and health equity and to adopt and implement policies for research for health that are aligned with national health plans, that include the participation of all relevant sectors, public and private, that align external support around mutual priorities, and that strengthen key national institutions;
 - (2) to consider drawing on the strategy on research for health according to their own national circumstances and contexts, and as part of their overall policies on health and health research;
 - (3) to strengthen national health research systems by improving the leadership and management of research for health, focusing on national needs, establishing effective institutional mechanisms for research, using evidence in health policy development, and harmonizing and coordinating national and external support (including that of WHO);
 - (4) to establish, as necessary and appropriate, governance mechanisms for research for health, to ensure rigorous application of good research norms and standards, including protection for human subjects involved in research, and to promote an open dialogue between policy-makers and researchers on national health needs, capacities and constraints;
 - (5) to improve the collection of reliable health information and data and to maximize, where appropriate, their free and unrestricted availability in the public domain;
 - (6) to promote intersectoral collaboration and high-quality research in order to produce the evidence necessary for ensuring that policies adopted in all sectors contribute to improving health and health equity;
 - (7) to initiate or strengthen intercountry collaboration with the aim of obtaining efficiencies of scale in research through the sharing of experiences, best practices and resources, the pooling of training and procurement mechanisms, and the use of common, standardized evaluation methods for research;
 - (8) to consider, where appropriate, establishment of regional collaborating mechanisms, such as centres of excellence, in order to facilitate access by Member States to the necessary research and expertise to meet health challenges;
 - (9) to continue to pursue financing of research for health as articulated in resolution WHA58.34 on the Ministerial Summit on Health Research;
3. INVITES Member States, the health research community, international organizations, supporters of research, the private sector, civil society and other concerned stakeholders:
 - (1) to provide support to the Secretariat in implementing the research for health strategy and in monitoring and evaluating its effectiveness;

¹ See Annex 4.

(2) to collaborate with the Secretariat, within the framework of the strategy, in identifying priorities for research for health, in developing guidelines relating to research for health and in the collection of health information and data;

(3) to assist the Secretariat and WHO's research partners in mobilizing enhanced resources for the identified global priorities for research for health;

(4) to pay particular attention to the research needs of low-income countries, notably in areas such as technology transfer, research workforce, and infrastructure development and the determinants of health particularly where this will contribute to the achievement of the Millennium Development Goals, health equity and better health for all and to collaborate with WHO Member States and the Secretariat to better align and coordinate the global health research architecture and its governance through the rationalization of existing global health research partnerships, to improve coherence and impact, and to increase efficiencies and equity;

(5) to support, where appropriate, technical cooperation among developing countries in research for health;

4. REQUESTS the Director-General:

(1) to provide leadership in identifying global priorities for research for health;

(2) to implement the strategy within the Organization at all levels and with partners, and in line with the references to research for health in the Global strategy and plan of action on public health, innovation and intellectual property;

(3) to improve the quality of research within the Organization;

(4) to provide adequate core resources in proposed programme budgets for the implementation of the research for health strategy;

(5) to ensure that the highest norms and standards of good research are upheld within WHO, including technical, ethical and methodological aspects and the translation into practice, use and dissemination of results and to review and align the architecture and governance of the Organization's research activities and partnerships;

(6) to provide support to Member States, upon request and as resources permit, in taking relevant actions to strengthen national health research systems and intersectoral collaborations;

(7) to strengthen the role of WHO collaborating centres as a well-established, effective mechanism for cooperation between the Organization and countries in the field of research for health;

(8) to report to the Sixty-fifth World Health Assembly on the implementation of this resolution, through the Executive Board, in 2012.

(Twelfth meeting, 26 January 2009)

EB124.R13 Human organ and tissue transplantation

The Executive Board,

Having considered the report on human organ and tissue transplantation,¹

RECOMMENDS to the Sixty-second World Health Assembly the adoption of the following resolution:²

The Sixty-second World Health Assembly,

Recalling resolutions WHA40.13, WHA42.5 and WHA44.25 on organ procurement and transplantation and WHA57.18 requesting an update of the Guiding Principles on Human Organ Transplantation;

Having considered the report on human organ and tissue transplantation;

Aware of the growing magnitude and utility of human cell, tissue and organ transplantation for a wide range of conditions in low-resource as well as high-resource countries;

Committed to the principles of human dignity and solidarity which condemn the buying of human body parts for transplantation and the exploitation of the poorest and most vulnerable populations and the human trafficking that result from such practices;

Determined to prevent harm caused by the seeking of financial gain or comparable advantage in transactions involving human body parts, including organ trafficking and transplant tourism;

Convinced that the voluntary, non-remunerated donation of organs, cells and tissues from deceased and living donors helps to ensure a vital community resource;

Conscious of the extensive cross-boundary circulation of cells and tissues for transplantation;

Sensitive to the need for surveillance of adverse events and reactions associated with the donation, processing and transplantation of human cells, tissues and organs as such and for international exchange of such data to optimize the safety and efficacy of transplantation,

1. WELCOMES the WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation;³

¹ Document EB124/15.

² See Annex 7 for the financial and administrative implications for the Secretariat of this resolution.

³ See Annex 5.

2. URGES Member States:¹

(1) to implement the Guiding Principles on Human Cell, Tissue and Organ Transplantation in the formulation and enforcement of their own policies, laws and legislation regarding human cell, tissue and organ donation and transplantation where appropriate;

(2) to foster public awareness and understanding of the benefits as a result of the voluntary non-remunerated provision of cells, tissues and organs as such from deceased and living donors, in contrast to the physical, psychological and social risks to individuals and communities caused by trafficking in material of human origin and transplant tourism;

(3) to oppose the seeking of financial gain or comparable advantage in transactions involving human body parts, organ trafficking and transplant tourism, including by encouraging health-care professionals to notify relevant authorities when they become aware of such practices in accordance with national capacities and legislation;

(4) to promote equitable access to transplantation services in accordance with national capacities, which provides the foundation for public support of voluntary donation;

(5) to improve the safety and efficacy of donation and transplantation by promoting international best practices;

(6) to strengthen national and multinational authorities and/or capacities to provide oversight, organization and coordination of donation and transplantation activities, with special attention to maximizing donation from deceased donors and to protecting the health and welfare of living donors;

(7) to collaborate in collecting data including adverse events and reactions on the practices, safety, quality, efficacy, epidemiology and ethics of donation and transplantation;

(8) to encourage the implementation of globally consistent coding systems for human cells, tissues and organs as such in order to facilitate national and international traceability of materials of human origin for transplantation;

3. REQUESTS the Director-General:

(1) to disseminate the updated Guiding Principles on Human Cell, Tissue and Organ Transplantation as widely as possible to all interested parties;

(2) to provide support to Member States and nongovernmental organizations in order to ban trafficking in material of human origin and transplant tourism;

(3) to continue collecting and analysing global data on the practices, safety, quality, efficacy, epidemiology and ethics of donation and transplantation of human cells, tissues and organs;

¹ And regional economic international organizations where appropriate.

(4) to facilitate Member States' access to appropriate information on the donation, processing and transplantation of human cells, tissues and organs, including data on severe adverse events and reactions;

(5) to provide, in response to requests from Member States, technical support for developing national legislation and regulation on, and suitable systems for, donation and transplantation of human cells, tissues or organs, in particular by facilitating international cooperation;

(6) to review the Guiding Principles on Human Cell, Tissue and Organ Transplantation periodically in the light of national experience with their implementation and of developments in the field of transplantation of human cells, tissues and organs;

(7) to report to the Health Assembly at least every four years on actions taken by the Secretariat, as well as by Member States, to implement this resolution.

(Twelfth meeting, 26 January 2009)

EB124.R14 Confirmation of amendments to Staff Rules¹

The Executive Board

CONFIRMS, in accordance with Staff Regulation 12.2, the amendments to the Staff Rules that have been made by the Director-General, with effect from 1 January 2009 concerning the remuneration of staff in the professional and higher categories, education grant, dependent children, and special education grant travel.

(Twelfth meeting, 26 January 2009)

EB124.R15 Amendments to Staff Regulations

The Executive Board,

Having considered the report on amendments to Staff Rules and Staff Regulations,²

RECOMMENDS, in accordance with Staff Regulation 12.1, to the Sixty-second World Health Assembly the adoption of the following resolution:

¹ See Annex 6, and Annex 7 for the financial and administrative implications for the Secretariat of this resolution.

² Document EB124/34.

The Sixty-second World Health Assembly,

Noting the recommendations of the Executive Board with regard to the reassignment of staff, including those not involving promotion:

ADOPTS the proposed amendment to Staff Regulation 4.2;

ADOPTS the proposed amendment to Staff Regulation 4.3;

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

(Twelfth meeting, 26 January 2009)

EB124.R16 Salaries of staff in ungraded posts and of the Director-General

The Executive Board,

Having considered the report on amendments to Staff Rules and Staff Regulations,¹

RECOMMENDS to the Sixty-second World Health Assembly the adoption of the following resolution:

The Sixty-second World Health Assembly,

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

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

(Twelfth meeting, 26 January 2009)

¹ Document EB124/34.

DECISIONS

EB124(1) Review of nongovernmental organizations in official relations with WHO

The Executive Board, having considered and noted the report of its Standing Committee on Nongovernmental Organizations on the review of one third of the nongovernmental organizations in official relations with WHO,¹ and following up decision EB122(1), reached the decisions set out below.

Noting with appreciation their collaboration with WHO and commending the continuing dedication to the work of WHO, the Board decided to maintain in official relations with WHO the nongovernmental organizations whose names are followed by an asterisk in the Annex to the report.

Noting that reports had not been received, or had been received too late to be included in the review, or that further information was required, the Board decided to defer until its 126th session the review of relations with the following 25 nongovernmental organizations: Association of the Institutes and Schools of Tropical Medicine in Europe; CropLife International; Cystic Fibrosis Worldwide Inc.; FDI World Dental Federation; Helen Keller International; International Agency for the Prevention of Blindness; International Association for Dental Research; International Association of Hydatid Disease; International Association of Logopedics and Phoniatics; International Commission on Radiological Protection; International Diabetes Federation; International Federation of Oto-Rhino-Laryngological Societies; International League against Epilepsy; International Leprosy Association; International Network on Children's Health, Environment and Safety; International Organization against Trachoma; International Physicians for the Prevention of Nuclear War; International Solid Waste Association; International Union against Tuberculosis and Lung Disease; International Union for Conservation of Nature and Natural Resources; International Union of Immunological Societies; International Union of Toxicology; ORBIS International; World Blind Union; and the World Federation of Hydrotherapy and Climatotherapy.

Noting the reports from Collegium Internationale Neuro-Psychopharmacologicum, International Society of Hematology, and the International Union of Microbiological Societies, and taking into consideration expectations of the resumption of mutually agreed collaboration, the Board decided to defer the review of relations with these nongovernmental organizations for an additional year and to request each organization to submit a report on its relations with WHO and on the results of exchanges to agree collaboration plans for consideration by the Executive Board at its 126th session.

Noting that reports of collaboration remained outstanding from the International Association for Adolescent Health, the International Union of Psychological Science, and the World Association of Girl Guides and Girl Scouts, the Board decided to defer the review of their relations for a further year and requested that the nongovernmental organizations be informed that, should the reports not be forthcoming for consideration by the Executive Board at its 126th session, their official relations would be discontinued.

¹ See Annex 3.

The Board noted the information in the report¹ on the participation of nongovernmental organizations in intergovernmental meetings convened by a decision of WHO's governing bodies.

(Eleventh meeting, 26 January 2009)

EB124(2) Award of the Dr A.T. Shousha Foundation Prize

The Executive Board, having considered the report of the Dr A.T. Shousha Foundation Committee, awarded the Dr A.T. Shousha Foundation Prize for 2009 to Professor Huda Zurayk (Lebanon) for her significant contribution to public health research in the Eastern Mediterranean Region. The laureate will receive the equivalent of 2500 Swiss francs in United States dollars.

(Eleventh meeting, 26 January 2009)

EB124(3) Award of the Sasakawa Health Prize

The Executive Board, having considered the report of the Sasakawa Health Prize Selection Panel, awarded the Sasakawa Health Prize for 2009 to Dr Amal Abdurrahman al Jowder (Bahrain), for her outstanding innovative work in health development. The laureate will receive US\$ 30 000.

(Eleventh meeting, 26 January 2009)

EB124(4) Award of the United Arab Emirates Health Foundation Prize

The Executive Board, having considered the report of the United Arab Emirates Health Foundation Selection Panel, awarded the United Arab Emirates Health Foundation Prize for 2009 to the Integrated Perinatal Care Project, KK Women's and Children's Hospital (Singapore) and to the Georgian Respiratory Association (Georgia) for their outstanding contribution to health promotion. The laureates will each receive US\$ 20 000.

(Eleventh meeting, 26 January 2009)

EB124(5) Award of the State of Kuwait Prize for Research in Health Promotion

The Executive Board, having considered the report of the State of Kuwait Health Promotion Foundation Selection Panel, awarded the State of Kuwait Prize for Research in Health Promotion in 2009 to the National Centre for Workplace Health Promotion, Nofer Institute of Occupational Medicine (Poland) and Dr Shaikha Salim Al Arrayed (Bahrain) for their outstanding contribution to research to health promotion. The laureates will each receive US\$ 20 000.

(Eleventh meeting, 26 January 2009)

¹ Document EB124/25.

EB124(6) Award of the Dr LEE Jong-wook Memorial Prize for Public Health

The Executive Board, having considered the report of the Dr LEE Jong-wook Memorial Selection Panel, awarded the Dr LEE Jong-wook Memorial Prize for 2009 to the Infectious Diseases, AIDS and Clinical Immunology Research Center (Georgia) for its outstanding contribution in research into and prevention, treatment and control of HIV/AIDS, and research into and control of communicable diseases. The laureate will receive US\$ 85 000.

(Eleventh meeting, 26 January 2009)

EB124(7) Award of the Jacques Parisot Foundation Fellowship

The Executive Board, having considered the report of the Jacques Parisot Foundation Selection Panel, awarded the Jacques Parisot Foundation Fellowship for 2009 to Ms Livesy Abokyi Naaffoe (Ghana). The laureate will receive US\$ 5000.

(Eleventh meeting, 26 January 2009)

EB124(8) Appointment of representatives of the Executive Board at the Sixty-second World Health Assembly

The Executive Board, further to decision EB123(5) and in accordance with paragraph 1 of resolution EB59.R7, appointed its Chairman, Mr N.S. de Silva (Sri Lanka), ex officio, and three of the Vice-Chairmen, Sir Liam Donaldson (United Kingdom of Great Britain and Northern Ireland), Mr C. Vallejos (Peru) and Mr O.I. Touré (Mali), to represent the Board at the Sixty-second World Health Assembly. It was understood that, if any of those members were not available for the Health Assembly, the other Vice-Chairman, Dr H. Abdesselem (Tunisia), and the Rapporteur, Dr Ren Minghui (China), could be asked to represent the Board.

(Eleventh meeting, 26 January 2009)

EB124(9) Provisional agenda for, and duration of, the Sixty-second World Health Assembly

The Executive Board, having considered the report of the Director-General on the provisional agenda for the Sixty-second World Health Assembly,¹ recalling its earlier decision that the Sixty-second World Health Assembly should be held at the Palais des Nations in Geneva, opening on Monday, 18 May 2009, and closing no later than Wednesday, 27 May 2009,² and recalling also the agreement made during the discussion of item 7.4 of the present session on the draft provisional agenda, approved the provisional agenda of the Sixty-second World Health Assembly, as amended.

(Eleventh meeting, 26 January 2009)

¹ Documents EB124/27, EB124/27 Add.1 and EB124/27 Add.2.

² See decision EB123(7).

EB124(10) Date and place of the 125th session of the Executive Board

The Executive Board decided that its 125th session should be convened on 28 May 2009, at WHO headquarters, Geneva, and should close no later than 30 May 2009.

(Eleventh meeting, 26 January 2009)

ANNEXES

ANNEX 1

Climate change and health

Workplan¹

[EB124/11 – 20 November 2008]

1. There is a strong, global, scientific consensus that warming of the climate system is a fact and is affecting human health. In view of the evidence, the Sixty-first World Health Assembly, in its resolution WHA61.19 requested, inter alia, the Director-General to consult Member States on the preparation of “a workplan for scaling up WHO’s technical support to Member States for assessing and addressing the implications of climate change for health and health systems”. [...]

2. The workplan is a framework for action by the Secretariat, taking into account the climates, cultures, socioeconomic development, health systems, health status and vulnerability across Member States. It was prepared through a consultative process, building on regional committee resolutions and regional frameworks for action, and further incorporating suggestions from Member States submitted electronically and in a meeting attended by 22 countries² nominated by the WHO Regional Directors (Geneva, 9–10 October 2008).

3. The workplan is organized around four objectives. It will be implemented within the timeframe of the current Medium-term strategic plan 2008–2013. The central focus is on environmental risks to health (i.e. under strategic objective 8), but several actions require the incorporation of climate-change considerations into other strategic objectives, work on which is in hand.

OVERALL AIM

4. The workplan aims to:

- support health systems in all countries, in particular low- and middle-income States and small island States, in order to enhance capacity for assessing and monitoring health vulnerability, risks and impacts due to climate change;
- identify strategies and actions to protect human health, particularly of the most vulnerable groups; and
- share knowledge and good practices.

¹ See resolution EB124.R5 and document EB124/2009/REC/1, summary record of the seventh meeting.

² Bangladesh, Barbados, Brazil, China, Costa Rica, Denmark, El Salvador, Germany, India, Italy, Jordan, Madagascar, Maldives, Norway, Oman, Poland, Republic of Korea, Russian Federation, Samoa, Serbia, Spain, United Kingdom of Great Britain and Northern Ireland.

OBJECTIVES AND ACTION

Objective 1. Advocacy and awareness raising

5. Raising awareness of the effects of climate change on health, in order to prompt action for public health measures. A better understanding of the risks and effects of climate change on health will motivate and facilitate both behavioural change and societal support for actions taken to reduce greenhouse gas emissions. Improved awareness will help health-sector professionals to provide leadership in supporting rapid and comprehensive strategies for mitigation¹ and adaptation² that will both improve health and reduce vulnerability.

Action

6. The Secretariat will undertake two actions, set out below.

Action 1.1 Development of tools, guidance, information and training packages to support awareness and advocacy campaigns to protect health from climate change at national and regional levels.

7. This action will target different population groups, especially health professionals. Education packages for the general public, particularly vulnerable groups such as children and the elderly, will be produced in collaboration with national authorities and nongovernmental organizations.

Action 1.2 Develop and run a global awareness-raising and advocacy campaign aiming to put health at the centre of the climate change mitigation and adaptation agenda at the international level.

8. This campaign aims to ensure that health is fully considered in the negotiations being carried out towards the 15th Conference of the Parties to the United Nations Framework Convention on Climate Change, scheduled to be held in Copenhagen, in December 2009. The campaign will also aim to clarify the role and necessary actions of the population, policy-makers and others for implementing health-related measures to enhance adaptation and reduce greenhouse gases. In this regard, the benefits for health of different choices in areas such as energy production and transport, will be clarified and quantified. The campaign will use standard methods and will also use innovative approaches on multimedia platforms. Relevant youth groups and nongovernmental organizations will be actively involved.

Objective 2. Engage in partnerships with other United Nations organizations and sectors other than the health sector at national, regional and international levels, in order to ensure that health protection and health promotion are central to climate change adaptation and mitigation policies

9. Partnerships will be sought at all levels. This requires the public health sector to play a stewardship role in fostering policy coherence across sectors, and to influence policies and actions that can benefit health.

Action

10. The Secretariat will undertake three actions.

¹ In this context, mitigation means action to reduce human effects on the climate system, principally strategies to reduce emissions of greenhouse gases, or enhance their removal from the atmosphere.

² Adaptation means adjustment that moderates harm or exploits beneficial opportunities in natural or human systems in response to actual or expected climatic stimuli or their effects.

Action 2.1 Participate in the relevant mechanisms and coordination activities within the United Nations system.

11. Particular attention will be given to the United Nations Framework Convention on Climate Change, Nairobi Work Programme on impacts, vulnerability and adaptation to climate change. The Secretariat will work to ensure that health concerns are fully taken into account in decision-making, resource allocation and outreach activities.

Action 2.2 Exercise WHO stewardship role with other sectors and related United Nations organizations.

12. Interaction with other sectors will be enhanced through the production of specific tools and information material to clarify the impact that different development choices (e.g. in the transport and energy sectors) could have in promoting and protecting health. Joint projects with other sectors (e.g. agriculture and emergency management) will address the need for intersectoral collaboration in order to improve effectiveness of adaptation responses.

Action 2.3 Provide the health sector with information, tools and advice so it can actively participate in national, regional and international mechanisms.

13. Health representatives need to ensure that health concerns are adequately integrated into national committees, National Adaptation Programmes of Action and regional and international adaptation and mitigation strategies. The Secretariat will provide Member States with information and data as well as advocacy instruments in order to support the preparation of the necessary documentation at country level, to facilitate access to resources and strategically position health into current and future national and international policies.

Objective 3. Promote and support the generation of scientific evidence

14. There are some important gaps in our knowledge, in particular about the current and potential future impacts of climate-related risks, the degree of population vulnerability, characteristics of vulnerable groups, the type of surveillance and alert and emergency management systems, the most useful indicators for monitoring and evaluation of the criteria for action, as well as the comparative effectiveness of different adaptation and mitigation policies for health promotion and protection.

Action

15. The Secretariat will undertake seven actions.

Action 3.1 Assess the burden of disease attributable to climate change and project it to future years using existing and new approaches.

16. The Secretariat will work closely with other relevant scientific bodies to update earlier estimates and include new indirect outcomes not considered in previous calculations. Existing tools to facilitate the application of the outcomes to regional, national and local levels will be revised and enhanced.

Action 3.2 Review and develop methodologies and guidelines on how to evaluate vulnerability to climate change-related health effects at local, national and regional levels.

17. Vulnerability assessments provide a better understanding of current and future risks to health, along with associated uncertainties. They also facilitate the identification of the interventions that can reduce pressure on

climate-sensitive health determinants, increase population resilience to climate change, and enhance capacity for preparedness and response to emergencies.

Action 3.3 Develop a clearinghouse of existing health protection strategies in Member States and make the information widely available. Assess comparative effectiveness, including cost-effectiveness.

18. Some countries and regions are undertaking or planning strategies and actions. There is a need to document and disseminate these developments, and share and assess their effectiveness.

Action 3.4 Support and monitor research to improve public health knowledge on the health risks of climate change and on the most effective interventions to manage those risks.

19. WHO has held a formal consultation process with leading researchers, bodies in the United Nations system, nongovernmental organizations and donors, and has defined priority areas for future research under the headings defined in resolution WHA61.19. It will work with these and other relevant partners to establish the financial and coordination mechanisms necessary to address the identified knowledge gaps and build the necessary research capacity, particularly in developing countries.

Action 3.5 Assess the health impact of adaptation and mitigation policies in other sectors and identify the most effective actions which have the potential to benefit health.

20. The choices made by other sectors, such as energy, agriculture and transport, have a direct impact on human health. A clarification of the health implications of mitigation and adaptation decisions in these sectors and the development of tools for their evaluation at regional, national and local level will support achievement of health benefits, and avoidance of health risks.

Action 3.6 Identify and develop indicators to monitor climate change-related health outcomes within surveillance systems.

21. Existing surveillance systems will be reviewed to identify indicators that could be used for identifying and assessing climate-related health risks and the effectiveness of actions. New indicators will be proposed if necessary.

Action 3.7 Work with other relevant scientific organizations to develop a comprehensive international assessment of the economic costs associated with the health effects of climate change under different scenarios of adaptation and mitigation action and/or inaction. Provide Member States with means for conducting such assessments at the national level.

22. The Intergovernmental Panel on Climate Change, Fourth Assessment Report (2001) and the Stern Review on the Economics of Climate Change (2006) have clarified the economic impact of climate change in society as a whole and in specific economic sectors. A similar assessment for the health effects would benefit policy development and strengthen the argument for appropriate action to mitigate and adapt to climate change.

Objective 4. Strengthen health systems to cope with the health threats posed by climate change, including emergencies related to extreme weather events and sea-level rise

23. Health-system action to protect populations from the impacts of climate change will need to encompass public health interventions within the formal health sector, such as control of neglected tropical diseases and provision of primary health care, and actions to improve the environmental and social determinants of health, ranging from access to clean water and sanitation to enhancing the welfare of women. A common theme must be ensuring equity and giving priority to protecting the health security of particularly vulnerable groups.

24. In addition, there is a particular need to control and reduce health risks, and strengthen coordinated preparedness and response in respect of the health effects of acute emergencies and other crises that may be exacerbated by climate variability and change.

Action

25. The Secretariat will undertake six actions.

Action 4.1 Provide technical support for building capacity to assess and monitor vulnerability to climate change-related health risks.

26. The Secretariat will collaborate with countries to develop national capacity for hazard, vulnerability, risk and capacity assessments with a particular focus on low- and middle-income countries and on small-island developing States. This will include training in the use of specific tools prepared in the different relevant technical areas.

Action 4.2 Advocate for the strengthening of primary health care (including primary prevention) services to support capacity of local communities to become resilient to climate-related health risks.

27. Many of the responses to the health challenges posed by climate change will require primary health care, including primary prevention, interventions in areas such as vector management, environmental health protection, and disease surveillance.

Action 4.3 Mobilize and guide international support for the urgent strengthening and financing of public health systems at the national level.

28. The Secretariat will support the health sector in Member States to engage in international climate change-related mechanisms, in order to access the necessary financial and political support to implement effective health adaptation responses to climate change. The development of health infrastructure must take account of the risks of climate change to ensure that it is safe and can function in emergencies.

Action 4.4 Support the preparation, implementation and evaluation of regional and national mitigation and adaptation plans requiring health-system action.

29. The Secretariat will work with countries to establish and evaluate action plans both in the area of specific responsibility of the health sector and in other sectors where actions have an impact on health and on health-sector resources. The need for incorporating climate change into existing health programmes and scaling-up of disaster risk reduction, emergency preparedness and response capacities in order to meet the increased risk of emergencies, will be strongly emphasized. In addition, support will be provided to Member States that want to reduce greenhouse gas emissions within their health sector.

Action 4.5 Standardize and support the development of early warning systems related to the health consequences of climate change and climate variability.

30. Several countries use warning systems to inform the population on how to prepare for, and cope with, health risks associated with weather-related events. WHO will work with other actors such as meteorological agencies, and participate in experience-sharing, standardization, and wider implementation of effective strategies.

Action 4.6 Support the assessment of the effectiveness of health emergency management measures in reducing the impact of extreme events on health with the development of appropriate evaluation methods and pilot studies.

31. The Secretariat will support more systematic evaluations of the accuracy of warnings, and the effectiveness of the social, preventive and clinical responses, in protecting health in vulnerable population groups. The effects of climate change on health, the long-term risks stemming from drought and sea-level rise that could affect water and food security and safety, competition for resources, and displacement of populations with humanitarian needs, should all be integrated into early warning systems with appropriate evaluation schemes.

IMPLEMENTATION

32. The activities described in this workplan will be implemented in support of countries through the WHO network at all levels as well as by making effective use of the relevant WHO collaborating centres and the expertise of other relevant bodies such as the Intergovernmental Panel on Climate Change. If necessary, new WHO collaborating centres will be designated to support implementation in some geographical areas and on specific issues. Collaboration with national and international centres of scientific excellence will be enhanced with particular emphasis on working with institutions from those countries that are most vulnerable to the effects of climate change on health. Monitoring and evaluation will be carried out through the mechanisms and indicators included within the Medium-term strategic plan 2008–2013 as well as the Programme budget of each relevant biennium. It is estimated that, despite the sharp increase in activities, the budget for the bienniums 2008–2009 and 2010–2011 will cover the needs. However, the planned budget for the biennium 2012–2013 should be re-assessed on the basis of the actions being developed over the present and next bienniums, and the requirements of Member States for collaboration and support.

ACTION BY THE EXECUTIVE BOARD

33. [In this paragraph the Executive Board was invited to provide guidance on the workplan.]

ANNEX 2

Amendments to the Financial Regulations and Financial Rules¹

Report by the Director-General

[EB124/22 – 18 December 2008]

1. At its 120th session in January 2007, the Executive Board considered a report on amendments to the Financial Regulations and Financial Rules.² The report, submitted by the Director-General, indicated that the Secretariat had embarked on a far-reaching endeavour to modernize essential operational systems in support of the results-based management framework to which the Organization is committed. As part of this modernization, and in line with similar initiatives throughout the United Nations system, the introduction of the International Public Sector Accounting Standards (IPSAS), was endorsed by the Health Assembly in resolution WHA60.9.

2. WHO is already introducing many individual standards as authorized within the United Nations System Accounting Standards and is committed to implementing IPSAS fully as from 1 January 2010. Full introduction of IPSAS requires amendments to be made to both the Financial Regulations and the Financial Rules. The proposed changes are set out in Appendices 1³ and 2.

AMENDMENTS TO FINANCIAL REGULATIONS AND FINANCIAL RULES

3. The adoption of IPSAS, and other related reforms, have major implications for the Organization. The effect of the proposed amendments to the Financial Regulations and Financial Rules are summarized below:

- In adopting IPSAS, WHO will undertake to follow all IPSAS or risk a qualified audit opinion on grounds of non-compliance.
- IPSAS require financial statements to be prepared annually under the accrual basis of accounting; however they accommodate those organizations with biennial budgets. (IPSAS 1 paragraph 66, and IPSAS 24 paragraph 38).

¹ See resolution EB124.R10.

² Documents EB120/21 and EB120/21 Corr.1.

³ The text reproduced in Appendix 1 is that recommended by the Programme, Budget and Administration Committee (see document EB124/3).

- The required financial statements are:
 - statement of financial position (balance sheet)
 - statement of financial performance (income statement)
 - statement of changes in net assets/equity
 - cash flow statement
 - comparison of budgeted amounts and actual amounts for the reporting period
 - notes, including a summary of significant accounting policies.

...¹

- Under the accrual basis, expenditure is recognized on the delivery principle, which is an important improvement over the obligation/commitment principle used in the past. At the end of each year, the figures for expenditure/budget implementation will reflect what has actually happened with the undelivered commitments not being recognized as expenditure until their delivery in the subsequent year. The proposed changes to Financial Regulation 4.2 take account of this.
- With IPSAS, annual accounts are prepared on the accrual basis, albeit with a biennial budget prepared on the cash basis, as is currently the case. Budget proposals will comprise the total effective budget for all programme activities under the control of the Organization, a part of which will be appropriated for financing by assessed contributions.

...¹

4. It is suggested that the effective date of implementation of the proposed changes should be 1 January 2010. This would complete the changes to the Financial Regulations required in line with the preparations for the introduction of IPSAS throughout the United Nations system.²

ACTION BY THE EXECUTIVE BOARD

5. [This paragraph contained a draft resolution that was adopted at the eleventh meeting as resolution EB124.R10.]

¹ Amendments not implemented following discussions in the Programme, Budget and Administration Committee; see document EB124/2009/REC/2, summary record of the eleventh meeting, section 2.

² For the full list of the accounting standards as currently issued by the IPSAS Board, see document EB124/22, Annex 3.

APPENDIX 1

TEXT OF PROPOSED AMENDMENTS TO THE FINANCIAL REGULATIONS

EXISTING TEXT AS OF 1 JANUARY 2008

PROPOSED REVISED TEXT

Regulation I – Applicability and Delegation of Authority

1.1 These Regulations shall govern the financial administration of the World Health Organization.

[No change]

1.2 The Director-General is responsible for ensuring effective financial administration of the Organization in accordance with these Regulations.

[No change]

1.3 Without prejudice to Regulation 1.2 the Director-General may delegate in writing to other officers of the Organization such authority as he or she considers necessary for the effective implementation of these Regulations.

1.3 Without prejudice to Regulation 1.2 the Director-General may delegate in writing to other officers of the Organization such authority **and related accountability** as he or she considers necessary for the effective implementation of these Regulations.

1.4 The Director-General shall establish Financial Rules, including relevant guidelines and limits for the implementation of these Regulations, in order to ensure effective financial administration, the exercise of economy, and safeguard of the assets of the Organization.

[No change]

Regulation II – The Financial Period

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

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

Regulation III – The Budget

3.1 The budget estimates for the financial period, as referred to in Article 55 of the Constitution (hereinafter referred to as “budget proposals”), shall be prepared by the Director-General.

3.1 The budget estimates for the financial period, as referred to in Article 55 of the Constitution (hereinafter referred to as “budget proposals”), shall be prepared by the Director-General. **The budget proposals shall be presented in United States dollars.**

~~3.1 bis The Director-General may also present estimates for a separate budget for capital expenditure.~~

3.2 The budget proposals shall cover gross income and gross expenditure for the financial period to which they relate, and shall be presented in United States dollars.

~~3.2 The budget proposals shall cover gross income and gross expenditure for the financial period to which they relate, and shall be presented in United States dollars.~~

3.3 The budget proposals shall be divided into parts, sections and chapters, and shall include such information, annexes and explanatory statements as may be requested by, or on behalf of, the Health Assembly and such further annexes or statements as the Director-General may deem necessary and useful.

3.2 The budget proposals shall be divided into parts, sections and chapters, and shall include such information, annexes and explanatory statements as may be requested by, or on behalf of, the Health Assembly and such further annexes or statements as the Director-General may deem necessary and useful.

EXISTING TEXT AS OF 1 JANUARY 2008

3.4 The Director-General shall submit the budget proposals at least 12 weeks before the opening of the regular session of the Health Assembly, and before the opening of the appropriate session of the Executive Board, at which they are to be considered. At the same time, the Director-General shall transmit these proposals to all Members (including Associate Members).

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

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

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

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

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

Regulation IV – Regular Budget Appropriations

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

PROPOSED REVISED TEXT

3.3 The Director-General shall submit the budget proposals at least 12 weeks before the opening of the regular session of the Health Assembly, and before the opening of the appropriate session of the Executive Board, at which they are to be considered. At the same time, the Director-General shall transmit these proposals to all Members (including Associate Members).

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

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

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

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

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

[No change]

EXISTING TEXT AS OF 1 JANUARY 2008

4.2 Appropriations shall be available for obligation for the financial period to which they relate. The Director-General is authorized to charge, as an obligation against the appropriations during the current financial period, the cost of goods or services which were contracted during the current financial period, and which are contractually due to be delivered during that period.

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

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

4.5 Appropriations in respect of the regular budget for the current financial period may remain available for the following financial period to pay for all goods and services resulting from legal commitments that were made before the end of the financial period, for completion the following year.

4.6 At the end of the financial period, any unobligated balance of the appropriations shall be credited to Miscellaneous Income.

4.7 Any claims for goods and services contractually due to be delivered in a subsequent financial period that exist against the Organization at the end of a financial period shall be established as obligations against appropriations established for the relevant subsequent financial period and shall be disclosed as a note to the Financial Statements.

PROPOSED REVISED TEXT

4.2 Appropriations shall be available for ~~obligation~~ **for making commitments in** the financial period to which they relate **for delivery in that financial period or the subsequent calendar year.** ~~The Director-General is authorized to charge, as an obligation against the appropriations during the current financial period, the cost of goods or services which were contracted during the current financial period, and which are contractually due to be delivered during that period.~~

[No change]

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

~~4.5 Appropriations in respect of the regular budget for the current financial period may remain available for the following financial period to pay for all goods and services resulting from legal commitments that were made before the end of the financial period, for completion the following year.~~

~~4.6 At the end of the financial period, any unobligated balance of the appropriations shall be credited to Miscellaneous Income.~~

~~4.7 Any claims for goods and services contractually due to be delivered in a subsequent financial period that exist against the Organization at the end of a financial period shall be established as obligations against appropriations established for the relevant subsequent financial period and shall be disclosed as a note to the Financial Statements.~~

EXISTING TEXT AS OF 1 JANUARY 2008**PROPOSED REVISED TEXT***Regulation V – Provision of Regular Budget Funds*

5.1 Appropriations shall be financed by assessed contributions from Members, according to the scale of assessments determined by the Health Assembly, and by Miscellaneous Income.

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

5.2 The amount to be financed by contributions from Members shall be calculated after adjusting the total amount appropriated by the Health Assembly to reflect that proportion of the regular budget to be financed by Miscellaneous Income.

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

5.3 In the event that the amount realized as Miscellaneous Income is greater than the amount approved by the Health Assembly under the regular budget proposals, any such surplus shall be credited to Miscellaneous Income for the following financial period, and shall be applied in accordance with the budget approved for that financial period.

~~5.3 In the event that the amount realized as Miscellaneous Income is greater than the amount approved by the Health Assembly under the regular budget proposals, any such surplus shall be credited to Miscellaneous Income for the following financial period, and shall be applied in accordance with the budget approved for that financial period.~~

5.4 In the event that the amount realized as Miscellaneous Income is less than the amount approved by the Health Assembly under the regular budget proposals, the Director-General shall review implementation plans for the regular budget in order to make any adjustments that may be necessary.

~~5.4 In the event that the amount realized as Miscellaneous Income is less than the amount approved by the Health Assembly under the regular budget proposals, the Director-General shall review implementation plans for the regular budget in order to make any adjustments that may be necessary.~~

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

Regulation VI – Assessed Contributions

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

[No change]

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

[No change]

EXISTING TEXT AS OF 1 JANUARY 2008**PROPOSED REVISED TEXT**

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

[No change]

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

[No change]

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

[No change]

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

[No change]

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

[No change]

6.8 Payments made by a Member and/or credits from Miscellaneous Income shall be credited to the Member's account and applied first against the oldest amount outstanding.

6.8 Payments made by a Member ~~and/or credits from Miscellaneous Income~~ shall be credited to the Member's account and applied first against the oldest amount outstanding.

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

[No change]

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

[No change]

6.11 New Members shall be required to make a contribution for the financial period in which they become Members at rates to be determined by the Health Assembly. When received, such unbudgeted assessments shall be credited to Miscellaneous Income.

6.11 New Members shall be required to make a contribution for the financial period in which they become Members at rates to be determined by the Health Assembly. ~~When received, such unbudgeted assessments shall be credited to Miscellaneous Income.~~ **Such contributions shall be recorded as income in the year in which they are due.**

EXISTING TEXT AS OF 1 JANUARY 2008*Regulation VII – Working Capital Fund and Internal Borrowing*

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

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

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

Regulation VIII – Miscellaneous and other Income

8.1 Miscellaneous Income shall be applied in accordance with Regulation V and shall include the following:

- (a) any unobligated balances within appropriations in accordance with Regulation 4.6;
- (b) any interest earnings or investment income on surplus liquidity in the regular budget;
- (c) any refunds or rebates of expenditure received after the end of the financial period to which the original expenditure related;
- (d) any proceeds of insurance claims that are not required to replace the insured item, or otherwise compensate for the loss;
- (e) the net proceeds generated on the sale of a capital asset after allowing for all costs of acquisition, or improvement, of any asset concerned;
- (f) any net gains or losses that may have arisen under operation of the exchange rate facility, or application of the official United Nations rates of exchange, or in revaluation for accounting purposes of the Organization's assets and liabilities;
- (g) any payments of arrears of contributions due from Member States that are not required to repay borrowings from the Working Capital Fund or internal borrowing in accordance with Regulation 7.3;

PROPOSED REVISED TEXT

[No change]

[No change]

[No change]

Regulation VIII – ~~Miscellaneous and other Income~~ Revenue: Other Sources

8.1 ~~Miscellaneous Income shall be applied in accordance with Regulation V and shall include the following:~~

- ~~(a) any unobligated balances within appropriations in accordance with Regulation 4.6;~~
- ~~(b) any interest earnings or investment income on surplus liquidity in the regular budget;~~
- ~~(c) any refunds or rebates of expenditure received after the end of the financial period to which the original expenditure related;~~
- ~~(d) any proceeds of insurance claims that are not required to replace the insured item, or otherwise compensate for the loss;~~
- ~~(e) the net proceeds generated on the sale of a capital asset after allowing for all costs of acquisition, or improvement, of any asset concerned;~~
- ~~(f) any net gains or losses that may have arisen under operation of the exchange rate facility, or application of the official United Nations rates of exchange, or in revaluation for accounting purposes of the Organization's assets and liabilities;~~
- ~~(g) any payments of arrears of contributions due from Member States that are not required to repay borrowings from the Working Capital Fund or internal borrowing in accordance with Regulation 7.3;~~

EXISTING TEXT AS OF 1 JANUARY 2008

(h) any income not otherwise specifically referred to in these Regulations.

8.2 The Director-General is authorized to levy a charge on extrabudgetary contributions in accordance with any applicable resolution of the Health Assembly. This charge shall be used, together with any interest earnings or earnings from investments of extrabudgetary contributions, in accordance with Regulation 11.3(b), to reimburse all, or part of, the indirect costs incurred by the Organization in respect of the generation and administration of extrabudgetary resources. All direct costs of the implementation of programmes that are financed by extrabudgetary resources shall be charged against the relevant extrabudgetary contribution.

8.3 Any refund of expenditure, or reimbursement for services and facilities provided, received from third parties during the biennium in which the original expenditure was incurred or services and facilities were provided shall be credited against that expenditure.

8.4 Any payments received from insurance policies held by the Organization shall be credited towards mitigating the loss that the insurance covered.

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

Regulation IX – Funds

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

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~~(h) any income not otherwise specifically referred to in these Regulations.~~

8.1 The Director-General is delegated the authority, under Article 5.7 of the Constitution, to accept gifts and bequest, either in cash or in kind, provided that he or she has determined that such contributions can be used by the Organization, and that any conditions which may be attached to them are consistent with the objective and policies of the Organization.

8.2 The Director-General is authorized to levy a charge on extrabudgetary contributions in accordance with any applicable resolution of the Health Assembly. This charge shall be **credited to the Special Account for Servicing Costs** used, together with any interest earnings or earnings from investments of ~~extrabudgetary~~ **extrabudgetary** contributions, ~~in accordance with Regulation 11.3(b), and used to~~ reimburse all, or part of, the indirect costs incurred by the Organization in respect of the generation and administration of ~~extrabudgetary~~ **such** resources. All direct costs of the implementation of programmes ~~that are financed by extrabudgetary resources~~ **that are financed by extrabudgetary resources** shall be charged against the relevant **budget**. ~~extrabudgetary contribution.~~

~~8.3 Any refund of expenditure, or reimbursement for services and facilities provided, received from third parties during the biennium in which the original expenditure was incurred or services and facilities were provided shall be credited against that expenditure.~~

~~8.4 Any payments received from insurance policies held by the Organization shall be credited towards mitigating the loss that the insurance covered.~~

[Renumbered 8.1]

[No change]

EXISTING TEXT AS OF 1 JANUARY 2008

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

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

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

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

Regulation X – Custody of Funds

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

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

Regulation XI – Investment of Funds

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

11.2 Income from investments shall be credited to the fund or account from which invested moneys derive unless otherwise provided in the regulations, rules or resolutions relating to that fund or account.

11.3(a) Income generated from regular budget resources shall be credited to Miscellaneous Income in accordance with Regulation 8.1.

PROPOSED REVISED TEXT

[No change]

[No change]

[No change]

[No change]

*Regulation X – Custody of ~~Funds~~ **Cash and Cash Equivalents***

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

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

*Regulation XI – Investment of ~~Funds~~ **Cash and Cash Equivalents***

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

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

~~11.3(a) Income generated from regular budget resources shall be credited to Miscellaneous Income in accordance with Regulation 8.1.~~ **Interest income generated from regular budget resources shall be available for appropriation by the Health Assembly, as per Regulation 5.1**

EXISTING TEXT AS OF 1 JANUARY 2008

(b) Income generated from extrabudgetary resources may be used to reimburse indirect costs related to extrabudgetary resources.

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

Regulation XII – Internal Control

12.1 The Director-General shall:

(a) establish operating policies and procedures in order to ensure effective financial administration, the exercise of economy, and safeguard of the assets of the Organization;

(b) designate the officers who may receive funds, incur financial commitments and make payments on behalf of the Organization;

(c) maintain an effective internal control structure to ensure the accomplishment of established objectives and goals for operations; the economical and efficient use of resources; the reliability and integrity of information; compliance with policies, plans, procedures, rules and regulations; and the safeguarding of assets;

(d) maintain an internal audit function which is responsible for the review, evaluation and monitoring of the adequacy and effectiveness of the Organization's overall systems of internal control. For this purpose, all systems, processes, operations, functions and activities within the Organization shall be subject to such review, evaluation and monitoring.

Regulation XIII – Accounts and Financial Reports

13.1 The Director-General shall establish such accounts as are necessary and shall, in so far as is not otherwise provided for in these Regulations and any Financial Rules established by the Director-General, maintain them in a manner consistent with the United Nations System Accounting Standards.

13.2 Final financial reports shall be prepared for each financial period, and interim financial reports shall be prepared at the end of the first year of each such period. Such financial reports shall be presented in conformity with – and in the formats established under – the Standards referred to in Regulation 13.1, together with such other information as may be

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~~(b) Income generated from extrabudgetary resources may be used to reimburse indirect costs related to extrabudgetary resources.~~

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

[No change]

Regulation XIII – Accounts and Financial Reports
~~Statements~~

13.1 The Director-General shall establish such accounts as are necessary and shall, ~~in so far as is not otherwise provided for in these Regulations and any Financial Rules established by the Director General,~~ maintain them in a manner consistent with the United Nations System Accounting Standards. **accordance with International Public Sector Accounting Standards.**

13.2 ~~Final financial~~ **Financial statements** reports shall be prepared **annually in accordance with International Public Sector Accounting Standards,** for each financial period, and interim financial reports shall be prepared at the end of the first year of each such period. Such financial reports shall be presented ~~in conformity with – and in the formats established~~

EXISTING TEXT AS OF 1 JANUARY 2008

necessary to indicate the current financial position of the Organization.

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

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

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

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

Regulation XIV – External Audit

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

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

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

14.4 The External Auditor(s) shall be completely independent and solely responsible for the conduct of the audit.

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

PROPOSED REVISED TEXT

~~under the Standards referred to in Regulation 13.1,~~ together with such other information as may be necessary to indicate the current financial position of the Organization.

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

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

[No change]

[No change]

[No change]

[No change]

[No change]

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

[No change]

EXISTING TEXT AS OF 1 JANUARY 2008	PROPOSED REVISED TEXT
14.6 The Director-General shall provide the External Auditor(s) with the facilities required for the performance of the audit.	<u>[No change]</u>
14.7 For the purpose of making a local or special examination or for effecting economies of audit cost, the External Auditor(s) may engage the services of any national Auditor-General (or equivalent title) or commercial public auditors of known repute or any other person or firm that, in the opinion of the External Auditor(s), is technically qualified.	<u>[No change]</u>
14.8 The External Auditor(s) shall issue a report on the audit of the biennium financial report prepared by the Director-General pursuant to Regulation XIII. The report shall include such information as he/she/they deem(s) necessary in regard to Regulation 14.3 and the Additional Terms of Reference.	<u>[No change]</u>
14.9 The report(s) of the External Auditor(s) shall be transmitted through the Executive Board, together with the audited financial report, to the Health Assembly not later than 1 May following the end of the financial period to which the final accounts relate. The Executive Board shall examine the interim and biennium financial reports and the audit report(s) and shall forward them to the Health Assembly with such comments as it deems necessary.	<u>[No change]</u>
<i>Regulation XV – Resolutions involving Expenditures</i>	
15.1 Neither the Health Assembly nor the Executive Board shall take a decision involving expenditures unless it has before it a report from the Director-General on the administrative and financial implications of the proposal.	<u>[No change]</u>
15.2 Where, in the opinion of the Director-General, the proposed expenditure cannot be made from the existing appropriations, it shall not be incurred until the Health Assembly has made the necessary appropriations.	<u>[No change]</u>
<i>Regulation XVI – General Provisions</i>	
16.1 These Regulations shall be effective as of the date of their approval by the Health Assembly, unless otherwise specified by the Health Assembly. They may be amended only by the Health Assembly.	<u>[No change]</u>
16.2 In case of doubt as to the interpretation and application of any of the foregoing regulations, the Director-General is authorized to rule thereon, subject to confirmation by the Executive Board at its next session.	<u>[No change]</u>

EXISTING TEXT AS OF 1 JANUARY 2008

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

PROPOSED REVISED TEXT

[No change]

APPENDIX 2

TEXT OF AMENDED FINANCIAL RULES*Rule I – Applicability and Delegation of Authority*

- 101.1 These Financial Rules are established in accordance with Financial Regulation 1.4.
- 101.2 The Director-General is responsible to the Health Assembly for the implementation of the Financial Rules in order to ensure effective financial administration, the exercise of economy, and safeguard of the assets of the Organization.
- 101.3 These Rules apply uniformly to all sources of funds, and all financial transactions of the Organization unless otherwise stated in these Rules.
- 101.4 The Financial Rules established by the Director-General, and any amendments thereto, shall enter into force after confirmation by the Executive Board.
- 101.5 In case of doubt as to the interpretation and application of any of the Financial Rules, the Director-General shall rule thereon.
- 101.6 In addition to the delegations of authority to designated officials expressed in these Financial Rules, and without prejudice to Financial Rule 101.2, the Director-General may delegate in writing, together with authorization for re-delegation to other officers of the Organization, such authority considered necessary by the Director-General for the implementation of these Rules, including for the issuance of operational procedures. All designated officials shall be responsible and accountable to the Director-General for the exercise of any authority delegated to them.

Rule II – The Budget

- 102.1 Biennial budget proposals, and supplementary proposals if appropriate, reflecting all sources of funds in such manner and at such times as may be required shall be drawn up and submitted by designated officials to the Director-General.
- 102.2 The biennial budget proposals may be submitted to the Regional Committees which shall comment and make recommendations thereon.
- 102.3 In implementation of Financial Regulation 4.4, the Director-General's budget proposals to the Health Assembly shall include proposals for the application and limit of the Exchange Rate Facility for that biennium.

Rule III – Regular Budget Appropriations

- 103.1 The appropriations approved by the Health Assembly constitute an authority to issue awards up to the amount approved to enable expenditures to be incurred for the purposes for which the appropriations were approved. The Director-General may determine the maximum amount of the appropriations that it would be prudent to issue as awards taking into account the prospects for payment of assessed contributions and the availability of both the Working Capital Fund and internal borrowing.

Rule IV – Financing

- 104.1 The assessments of Members, in accordance with Financial Regulations 5.1–5.2 shall be computed on the basis of the membership of the Organization as at the last day of the relevant Health Assembly.
- 104.2 In order that the Director-General may accept payment of Members' assessed contributions under Financial Regulation 6.7 in currencies that are not fully convertible, the following limits and guidelines shall apply:
- (a) the amount due shall be expressed in United States dollars;
 - (b) payments to WHO shall be required to be made on a specified date to a specific bank account;
 - (c) the amounts of any payment authorized shall be no greater than the expected monthly net cash outflow of the Organization in the currency concerned;
 - (d) for the purpose of crediting the relevant Members' account with WHO in United States dollars, the United Nations rate of exchange effective on the date of receipt by WHO shall apply.
- 104.3 Any payments in currencies, other than those specified in Financial Regulation 6.6 (United States dollars, euros or Swiss francs), that do not comply with the specific terms of any approval given by the Director-General shall be automatically returned to the relevant Member State, and the assessed contribution concerned shall continue to be due and payable.
- 104.4 In order for authorizations to be issued for expenditure, financing must be available, taking account of revenue recognized in accordance with International Public Sector Accounting Standards, of availability of cash or cash equivalents or other acceptable forms of financing in amounts determined by designated officials.
- 104.5 The use of the Working Capital Fund and the amount of internal borrowing together shall not exceed the total amount of unpaid assessed contributions, and shall in any event not exceed 25% of the assessed contributions for the biennium concerned.
- 104.6 In formulating proposals to the Health Assembly to vary the level of the Working Capital Fund in accordance with Financial Regulation 7.2, the Director-General shall take into consideration the level of internal borrowing that it would be prudent to incur and the limit specified in Financial Rule 104.5.
- 104.7 In accordance with Financial Regulation 7.1, in order to determine the level of reserves available to finance internal borrowing the Director-General shall take into account the projected income and expenditure of each cash reserve.

Rule V – Funding from Awards for Approved Workplans

- 105.1 Funding from awards for approved workplans shall be issued to designated officials as authorization to incur expenditure.

- 105.2 Designated officials to whom funding from awards is issued are accountable to the Director-General for the correct use of the resources made available.

Rule VI – Expenditure (Commitments)

- 106.1 In order to incur expenditure, commitments shall be made against award funding issued against approved workplans to designated officials.
- 106.2 Commitments may only be made by designated officials and shall be supported by satisfactory documentation. All commitments or undertakings that create liabilities against the resources of the Organization shall be represented by signed contracts or similar documentation that are prepared when the liability arises.
- 106.3 Commitments may be made only for the purpose indicated in the workplan and may not exceed the amount available in the award.
- 106.4 Proposals for expenditure, including procurement of goods and services, shall be rejected if they do not comply with the Financial Regulations, the present Rules, and the following conditions:
- (a) award funding is available;
 - (b) the procedures of the Organization are being observed;
 - (c) the financial situation of the Organization will not be prejudiced;
 - (d) the purpose of the proposed expenditure is in the interests of the work of the Organization.
- 106.5 Revisions to a commitment shall be subject to the same procedure as the original commitment.
- 106.6 Ex gratia payments may be authorized by the Director-General in accordance with Financial Regulation 13.5, provided such payments are justified in the interests of equity, or otherwise in the best interests of the Organization. Any such payment, together with an explanation of its justification, shall be promptly reported to both the External Auditor and the Head of the Office of Internal Oversight Services.

Rule VII – Internal Control

- 107.1 In order to ensure effective internal control within the Organization, in accordance with Financial Regulation XII, the Director-General shall establish measures, including (i) an internal audit framework as set out in Financial Rule XII, (ii) appropriate delegations of authority, (iii) segregation of duties, and (iv) other measures that are consistent with best financial practice.

- 107.2 Payments shall not be made in advance except as where otherwise specified in these Rules. Payments shall only be made on the basis of satisfactory supporting documents duly certified by designated officials confirming that:
- (a) services have been rendered or delivery has been completed in accordance with the terms of contract;
 - (b) the amount is correct and in accordance with the terms of the contract.
- 107.3 As an exception and only where operationally justified, contracts or purchase orders may be entered into which require part payment in advance prior to the delivery of goods or performance of services. The justification for any such arrangements shall be fully documented.
- 107.4 In order for any contract or purchase order to be entered into requiring full payment in advance, the official requesting such terms shall provide full justification and demonstrate why such payment terms are necessary in the interest of the Organization. All such payment terms shall be subject to approval by designated officials.
- 107.5 Designated officials may authorize advances to staff members and other persons in connection with the execution of official duties for WHO and staff entitlements.
- 107.6 Funds of the Organization shall be deposited only in banks or financial institutions or invested with counterparties determined by the Director-General in accordance with the investment policies referred to in Financial Rule 107.11.
- 107.7 The Director-General shall designate officials to be responsible for all bank accounts, and for the management, receipt and disbursement of all funds of the Organization and proper accounting thereof.
- 107.8 Imprest account holders shall be accountable for all funds under their responsibility.
- 107.9 Panels of signatories shall be designated by officials authorized by the Director-General. All payments from the Organization's bank accounts shall be signed by two officials of the appropriate panels. Where deemed necessary, in exceptional circumstances, those officials authorized to designate panels of signatories may authorize the signature of payments by one official only, provided that there are adequate safeguards for the protection of funds, including limits on the funds that may be paid from the account.
- 107.10 All securities shall be deposited in the custody of duly appointed banks or financial institutions designated by the Director-General.
- 107.11 Investment policies shall be drawn up in accordance with Financial Regulation 11.3. An advisory committee shall assist the Director-General in formulating these investment policies and in monitoring the performance of funds invested.

Rule VIII – The Accounts

- 108.1 The accounts shall comprise a consolidated general ledger of the Organization and subsidiary ledgers which shall include all financial transactions of the financial period in which they occur and which shall be accounted for on an accrual basis to enable the Organization to produce financial statements compliant with International Public Sector Accounting Standards. All periodic and other financial statements shall be prepared from these accounts.
- 108.2 Subject to Financial Rule 101.3, the Director-General shall determine those parts of the Organization that shall be authorized to maintain their own accounting records, and which shall be reported periodically with the accounts of the Organization.
- 108.3 All financial transactions and statements shall be supported by documentation to be retained as an integral part of the official records of the Organization for such period or periods as may be agreed with the External Auditor, after which, on the authority of designated officials, such records and documents may be destroyed.
- 108.4 All accounting transactions shall be recorded in the general and subsidiary ledgers in accordance with a uniform chart of accounts.
- 108.5 Income and expenditure shall be recorded in accordance with a uniform system of classification.

Rule IX – Financial Statements

- 109.1 The Director-General shall submit annual financial statements, taken from the accounts referred to in Financial Rule 108.1, to the Health Assembly and the Executive Board or to such committees of the Executive Board as may be responsible for review and comment thereon, no later than 1 May. Such financial statements shall be prepared in accordance with International Public Sector Accounting Standards, the Financial Regulations and the present Rules and shall include such other information as may be necessary to indicate the financial position of the Organization.
- 109.2 The annual financial reports shall also disclose any ex gratia payments and any losses of cash, supplies, equipment and other assets that have occurred during the period, indicating their treatment in the accounts.

Rule X – Property, Plant and Equipment

- 110.1 The acquisition and related depreciation of land, buildings, plant and equipment shall be capitalized in the accounts in accordance with International Public Sector Accounting Standards. Property, plant or equipment acquired under lease shall be capitalized or charged as expenditure in accordance with International Public Sector Accounting Standards.
- 110.2 Inventory records shall be maintained for all property, plant and equipment.
- 110.3 Periodic physical inventories shall be taken of all property, plant and equipment.

- 110.4 Property, plant and equipment may be declared to be surplus if it is of no further use to the Organization and disposed of for the best possible return to the Organization, including part-exchange, except when (i) destruction will be more economical or is required by law or environmental considerations, or (ii) the best interest of the Organization will be served by disposal by gift or at a nominal price to a non-profit organization.
- 110.5 The gain or loss from the derecognition of an item of property, plant or equipment shall be included in surplus or deficit. However, if an item is being replaced, any gain on derecognition of the replaced article shall serve to contribute towards the expenditure incurred in replacing the item.
- 110.6 Subject to the provisions of Financial Rule 104.4, goods and services may be provided to governments, specialized agencies, and other international organizations on a reimbursable or reciprocal basis on such terms and conditions as may be approved by designated officials.

Rule XI – Procurement of Goods and Services

- 111.1 The Director-General shall establish policies and procedures for the purchase of property, services, supplies, equipment or other requirements, and which shall set forth the requirements for invitations to tender and competitive bidding.
- 111.2 Contracts for the purchase of property, services, supplies, equipment or other requirements shall be entered into for and on behalf of the Organization only by designated officials.
- 111.3 All purchases and other contracts shall be made on the basis of competitive bids, except when otherwise authorized by designated officials.
- 111.4 Contracts are normally awarded to the lowest bidder. However, where it is considered to be in the interest of the Organization, the acceptance of a bid other than the lowest, or the rejection of all bids may be authorized by designated officials.

Rule XII – Internal Audit

- 112.1 The Office of Internal Oversight Services (IOS) is responsible for internal audit, inspection, monitoring and evaluation of the adequacy and effectiveness of the Organization's system of internal control, financial management and use of assets as well as investigation of misconduct and other irregular activities. All systems, processes, operations, functions and activities within the Organization are subject to IOS's review, evaluation and oversight.
- 112.2 The Director-General shall appoint a technically qualified head of IOS after consultation with the Executive Board. The Director-General shall likewise consult the Executive Board before any termination of the incumbent of that office.

- 112.3 IOS shall function in accordance with the following provisions:
- (a) the head of IOS shall report directly to the Director-General;
 - (b) IOS shall have full, free and prompt access to all records, property, personnel, operations and functions within the Organization which, in IOS's opinion, are relevant to the subject matter under review;
 - (c) IOS shall be available to receive directly from individual staff members complaints or information concerning the possible existence of fraud, waste, abuse of authority or other irregular activities. Confidentiality shall be respected at all times, and no reprisals shall be taken against staff members providing such information unless this was willfully provided with the knowledge that it was false or with intent to misinform;
 - (d) IOS shall report the results of its work and make recommendations to the Regional Director, Assistant Director-General, Director or other responsible manager for action, with a copy to the Director-General and the External Auditor. At the request of the head of IOS, any such report shall be submitted to the Executive Board, together with the Director-General's comments thereon;
 - (e) IOS shall submit a summary report annually to the Director-General with a copy to the External Auditor on IOS's activities, including the orientation and scope of such activities, as well as the implementation status of recommendations. This report shall be submitted to the Health Assembly together with comments deemed necessary.
- 112.4 The Director-General shall ensure that all IOS recommendations are responded to and implemented as appropriate.
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ANNEX 3

Nongovernmental organizations admitted into, or maintained in, official relations with WHO by virtue of, respectively, resolution EB124.R11 and decision EB124(1)

[EB124/25, Annex – 26 January 2009]

Aga Khan Foundation¹
Alzheimer's Disease International²
Association of the Institutes and Schools of Tropical Medicine in Europe
CBM³
Collegium Internationale Neuro-Psychopharmacologicum
Commonwealth Association for Health and Disability^{2,4}
CropLife International
Cystic Fibrosis Worldwide, Inc.
European Centre for Ecotoxicology and Toxicology of Chemicals
Family Health International²
FDI World Dental Federation
Helen Keller International
HelpAge International²
Inclusion International²
Inter-African Committee on Traditional Practices affecting the Health of Women and Children²
International Agency for the Prevention of Blindness
International Air Transport Association
International Association for Adolescent Health
International Association for Dental Research
International Association for Suicide Prevention²
International Association for the Study of Pain
International Association of Hydatid Disease
International Association of Logopedics and Phoniatries
International Clearinghouse for Birth Defects Surveillance and Research⁵
International Commission on Non-Ionizing Radiation Protection
International Commission on Radiological Protection

¹ Activities concern the period 2004–2006.

² Activities concern the period 2005–2007.

³ Previously known as the Christoffel-Blindenmission. Revised Articles of Association indicate Christoffel-Blindenmission Christian Blind Mission e.V. CBM. The nongovernmental organization uses the acronym CBM.

⁴ Previously known as the Commonwealth Association for Mental Handicap and Developmental Disabilities.

⁵ Previously known as the International Clearinghouse for Birth Defects Monitoring Systems.

International Council for Control of Iodine Deficiency Disorders¹
 International Council for Ophthalmology²
 International Diabetes Federation
 International Epidemiological Association³
 International Ergonomics Association¹
 International Eye Foundation, Inc.
 International Federation of Oto-Rhino-Laryngological Societies
 International Federation on Ageing¹
 International League Against Epilepsy
 International Leprosy Association
 International Life Sciences Institute
 International Medical Corps
 International Network on Children's Health, Environment and Safety
 International Non Governmental Coalition Against Tobacco¹
 International Organization against Trachoma
 International Pediatric Association¹
 International Physicians for the Prevention of Nuclear War
 International Planned Parenthood Federation¹
 International Society for Environmental Epidemiology⁴
 International Society of Doctors for the Environment
 International Society of Hematology
 International Solid Waste Association
 International Union against Cancer
 International Union against Sexually Transmitted Infections
 International Union against Tuberculosis and Lung Disease
 International Union for Conservation of Nature and Natural Resources
 International Union for Health Promotion and Education¹
 International Union of Immunological Societies
 International Union of Microbiological Societies
 International Union of Nutritional Sciences¹
 International Union of Psychological Science
 International Union of Pure and Applied Chemistry
 International Union of Toxicology
 International Water Association
 International Women's Health Coalition Inc.^{1,5}
 Islamic Organization for Medical Sciences
 La Leche League International¹
 March of Dimes Foundation⁶
 Medical Women's International Association¹
 ORBIS International
 Organisation pour la Prévention de la Cécité
 Rehabilitation International¹

¹ Activities concern the period 2005–2007.

² Previously known as the International Federation of Ophthalmological Societies.

³ Activities concern the period 2004–2006.

⁴ Activities concern the period 2003–2008.

⁵ Previously known as the International Women's Health Coalition.

⁶ Previously known as the March of Dimes Birth Defects Foundation.

Rotary International
Thalassaemia International Federation
The International Association of Lions Clubs
The International Federation of Anti-Leprosy Associations
The Population Council¹
The Royal Commonwealth Society for the Blind (Sight Savers International)
World Association of Girl Guides and Girl Scouts
World Blind Union
World Confederation for Physical Therapy¹
World Council of Optometry
World Federation for Mental Health¹
World Federation for Ultrasound in Medicine and Biology²
World Federation of Hemophilia
World Federation of Hydrotherapy and Climatotherapy
World Federation of the Deaf¹
World Heart Federation
World Hypertension League
World Plumbing Council
World Stroke Organization³
World Veterinary Association

¹ Activities concern the period 2005–2007.

² Activities concern the period 2004–2006.

³ Previously known as the International Stroke Society.

ANNEX 4

Draft WHO strategy on research for health¹

[EB124/12, Annex – 18 December 2008]

CONTEXT AND RATIONALE

Research, global health and WHO

1. This draft strategy sets out how to strengthen WHO's involvement in research for health and the consequent role of research within WHO. It recognizes that research is central to progress in global health and identifies ways in which the Secretariat can work with Member States and partners to harness science, technology and broader knowledge in order to produce research evidence and tools for improving health outcomes.
2. In all Member States, increasing demands are being placed on research to provide opportunities for resolving current and emerging health problems. In meeting the challenge of resolving priority problems across the spectrum of public health – whether it be tackling diseases of poverty, responding to the global epidemiological transition to chronic diseases, ensuring that mothers have access to safe delivery practices, or preparing for global threats to health security – research is indispensable.
3. In a global environment of competing demands for limited resources, it is especially important that health policies and practices should be informed by the best research evidence. The fundamental importance of research for WHO is identified in Article 2 of the Constitution of the World Health Organization; further, in the Eleventh General Programme of Work 2006–2015, the harnessing of knowledge, science and technology is highlighted as one of seven priority areas.
4. The Eleventh General Programme provides a global health agenda for the Organization, its Member States and the international community; however, although the value of research is widely recognized, exploiting research optimally to resolve priority health problems is not a straightforward matter. The complex nature of the health problems confronting societies, the rapid advances in knowledge and technologies related to health, the shifting expectations and concerns of the public in respect of research, and changes in the organization and management of research within and across countries, are among the many factors that must be taken into account.
5. Importantly, much progress has been made in recent decades. In parallel to the growing importance attached to health globally, attention is increasingly being focused by the broader research community on the health problems of the poor and disadvantaged. Significant research efforts, involving public–private partnerships and other innovative mechanisms, are being concentrated on neglected diseases in order to stimulate the development of vaccines, drugs and diagnostics where market forces alone are insufficient. Likewise, shared vulnerability to global infectious threats such as

¹ See resolution EB124.R12 and document EB124/2009/REC/2, summary record of the seventh meeting.

severe acute respiratory syndrome and avian influenza has mobilized global research efforts in support of enhancing capacity for preparedness and response in the areas of surveillance, rapid diagnostics and development of vaccines and medicines.

6. In addition to this progress, there is growing awareness that research systems are not responding optimally to the diverse demands that they face. Investments in health research are insufficient; further, they are not appropriately directed towards tackling priority health problems. In addition, when complex challenges are being met, such as tackling food insecurity or the effects of climate change, there has been a failure to draw on resources available for research in other sectors. Low-income countries are faced with a diverse range of donor-driven research agendas that often weaken national priorities, and many countries are facing significant challenges in training and retaining researchers.

7. Work in support of the ethical review and public accountability of research is not keeping pace with best practices. The opportunity of creating a shared framework for storing and sharing research data, tools and materials has not been seized with the same energy in the area of health as it has in other scientific fields, and policy-makers are neither contributing to research priorities nor using evidence to inform their decisions.

8. In view of the rapid changes taking place in public health and research, there is an urgent need for a systematic and comprehensive approach to organizing and managing research for health. This draft strategy seeks to define WHO's role in satisfying that need.

WHO's role in research for health

9. The Eleventh General Programme of Work identifies six core functions of WHO, one of which is: "shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge". The other five functions – which involve providing leadership, setting norms and standards, articulating evidence-based policy options, providing technical support and monitoring the health situation – all require strong research competencies among the staff of the Secretariat.

Definitions and concepts

10. The term "research for health" reflects the fact that improving health outcomes requires the involvement of many sectors and disciplines. As identified in the work of the Global Forum for Health Research, research of this type seeks to perform the functions of understanding the impact on health of policies, programmes, processes, actions or events originating in any sector; of assisting in developing interventions that will help prevent or mitigate that impact; and of contributing to the achievement of the Millennium Development Goals, health equity and better health for all. Research for health covers the full spectrum of research, which spans the following five generic areas of activity:

- measuring the magnitude and distribution of the health problem¹
- understanding the diverse causes or the determinants of the problem, whether they are due to biological, behavioural, social or environmental factors

¹ The term "health problem" is used in this strategy to refer to a major cause of ill-health or health inequity, whether actual or prospective. It includes the following: diseases such as HIV/AIDS or mental illness; risks to health such as obesity, poverty or climate change; and obstacles to effective systems performance, such as unsafe care or inequitable financing of health services.

- developing solutions or interventions that will help to prevent or mitigate the problem
- implementing or delivering solutions through policies and programmes
- evaluating the impact of these solutions on the level and distribution of the problem.

11. The draft strategy also draws on a systematic framework for health research systems, as presented in the *Bulletin of the World Health Organization* in the November 2003 issue.¹ In this framework four core functions are defined for research systems, namely: stewardship; financing; creating and sustaining the research workforce and infrastructure; and producing, synthesizing and using knowledge.

Development of the draft WHO strategy on research for health

12. In resolution WHA60.15 the Health Assembly requested the Director-General to develop a strategy for the management and organization of research activities within WHO. This represents an opportunity for the Organization to: (1) review and revitalize the role of research within WHO; (2) improve its support to Member States in building health research capacity; (3) strengthen its advocacy of the importance of research for health; and (4) better communicate its involvement in research for health.

13. The WHO strategy on research for health was developed by the Secretariat by means of an 18-month consultative process. The process involved staff at headquarters and regional and country offices, as well as key partners (including funding bodies, the private sector, the research community and nongovernmental organizations). An external reference group provided extensive comments on successive drafts of the strategy, as did ACHR.

14. Aware that a realistic, forward-looking strategy requires an informed understanding of past successes and failures and current realities, development of the strategy was also informed, inter alia, by:

- a historical review of research at WHO
- previous Health Assembly resolutions on research
- a comprehensive survey and analysis of current research activities across the 34 departments of the Secretariat and the special research programmes and centres.²

As requested by the Health Assembly in resolution WHA61.21, attention was given to ensuring that the development of WHO's research strategy reflected, as appropriate, the global strategy and plan of action on public health, innovation and intellectual property.

¹ *Bulletin of the World Health Organization* 2003, **81**(11): 815–820.

² "Research at WHO today", document in preparation.

DRAFT WHO STRATEGY ON RESEARCH FOR HEALTH

Research in the service of health

15. This comprehensive, Organization-wide strategy will underpin all the Secretariat's work.
16. The **vision** for the strategy is that decisions and actions to improve health and enhance health equity are grounded in evidence from research. The **mission** of the strategy is for the Secretariat, Member States and partners to work together to harness science, technology and broader knowledge in order to produce research-based evidence and tools for improving health.
17. The strategy reflects WHO's diverse roles and responsibilities in respect of research for health: the Organization works to provide stewardship and advocacy, convene funders, catalyse change, and build capacity; and it acts as a communicator, producer and user of research.
18. The strategy calls for changes in order to improve capacity to access and make use of existing research findings; and in order to better understand, and mobilize support for, the research needed for improving health and health outcomes.
19. In the strategy it is also recognized that achieving health goals requires a more effective involvement on the part of WHO with the broader global research community and funders of research, and with sectors other than health.

Guiding principles

20. The WHO strategy on research for health is grounded in three principles that will guide achievement of the goals and the realization of the vision.

Quality – WHO commits itself to high-quality research that is ethical, expertly reviewed, efficient, effective, accessible to all, and carefully monitored and evaluated.

Impact – WHO gives priority to research and innovation that has the greatest potential to improve global health security, accelerate health-related development, redress health inequities and help to attain the Millennium Development Goals.

Inclusiveness – The Secretariat undertakes to work in partnership with Member States and stakeholders, to take a multisectoral approach to research for health, and to support and promote the participation of communities and civil society in the research process.

Goals

21. Five interrelated goals have been defined to enable WHO to achieve the vision of the strategy.
 - **Organization** – this involves the strengthening of the research culture across WHO.
 - **Priorities** – this concerns the reinforcement of research (at national, regional and global levels, and within WHO) in response to priority health needs.
 - **Capacity** – this relates to the provision of support to the strengthening of national systems for health research.

- **Standards** – this concerns the promotion of good practice in research, drawing on WHO’s core function of setting norms and standards.
- **Translation** – this involves the strengthening of links between the policy, practice and products of research.

22. WHO needs to show it can lead by example, which is why the **Organization** goal is the foundation of the strategy. It is an essential part of the other four goals, defining the Secretariat’s interactions with Member States and partners in the activities for achieving each goal.

23. The current global health situation is complex and characterized by an array of new and existing health challenges, many of which call for greater efforts in the area of research. Given the competing needs of the different areas of research, it is essential not only to mobilize sufficient resources for research but also to ensure their careful distribution. WHO’s roles, in respect of the **priorities** goal, are as follows: to offer assistance in identifying, in a timely manner, priorities for research for health, especially those that can benefit the poorest members of society; and to mobilize all stakeholders in order to provide an effective response.

24. Strengthening Member States’ national systems research in support of health – the **capacity** goal – is essential for improving health delivery, health security and health outcomes. Efforts to attain this goal need to focus on institutional capacity-building in order to develop the necessary human resources and physical infrastructure for conducting research. Attention must also be directed towards satisfying the need for policy leadership, financing, and standards for research.

25. No country is self-sufficient in its research capacity, so Member States need to be able to share research outputs. Effective and equitable sharing requires internationally agreed norms and standards for research; with this in mind, the **standards** goal concerns the promotion of good practice in research by means of work to establish agreements on good practices, scientific benchmarks, ethical guidelines and accountability mechanisms. The achievement of this goal is essential for winning public support and confidence.

26. Finally, if the ultimate objective of research for health is to improve health outcomes, the generation of knowledge alone is not sufficient: knowledge has to be harnessed in order to inform policy and practice and develop products. In establishing the **translation** goal, WHO aims to facilitate a more productive interface between researchers and those who use evidence, including policy-makers and practitioners at national, regional and global levels.

27. A summary of the outputs generated in achieving each goal is shown in Table 1.

ORGANIZATION GOAL

28. The Organization goal is to strengthen the research culture across WHO.

The challenge

29. Consultations undertaken in developing the strategy generated a clear message, from both within the Organization and beyond, that WHO needs to undertake a major change in behaviour in order to keep pace with the evolving research environment and communicate better the nature of its own research activities.

30. The internal obstacles that WHO must overcome, identified during the consultation process, include:

- the lack of a common, well-articulated vision for research for health
- the fragmented and uncoordinated nature of research activities across the Organization
- the inconsistent use of evidence in establishing policies, programmes, and global norms and standards
- the absence of standards of research practice for staff producing and using research
- the insufficient number of staff with appropriate research skills and an adequate understanding of research
- the lack of a dedicated budget to support research activities
- the bureaucratic and financial arrangements that many research partners find awkward
- the lack of sufficient incentives and encouragement to ensure that staff are involved and that they improve their competencies in research or research-related activities.

31. The activities related to the **Organization** goal will tackle these obstacles by improving research practices in accordance with the strategy's three principles: quality, impact and inclusiveness. The aim is for WHO to have effective governance mechanisms for supporting the production, dissemination and use of research evidence both within the Organization and beyond.

32. WHO's guidance and programmes will therefore need to be informed by the best available research evidence. Further, the research activities with which WHO is affiliated will need to be aligned with a code of good research practice. A general understanding will also be required, both within WHO and beyond, of the central role played by research evidence in the Organization's activities and of the broader role of the Organization in research.

Actions to achieve the goal

33. Working with Member States and partners, the Secretariat will:

- (a) establish appropriate structures for keeping abreast of latest developments in knowledge management, interaction with the global research community, and leading, managing and coordinating research within WHO, and for maintaining accountability for such research; and secure the resources needed to support the implementation and evaluation of this strategy;
- (b) develop and implement a WHO code of good research practice for those of its staff involved with research and the use of evidence;
- (c) strengthen existing mechanisms for good research practice, including:
 - (i) ethical and peer review structures and procedures
 - (ii) the appropriate use of evidence to inform the development of guidelines
 - (iii) the regular review of core policies and programmes in the light of new evidence;

- (d) enhance the research-related competencies of relevant professional staff by applying designated criteria in their recruitment, by providing on-the-job training, and by identifying incentives for good research performance that are linked to regular evaluations;
- (e) improve the management and coordination of WHO-affiliated research, and develop a publicly accessible repository for all such research in order to improve access to the knowledge thus derived;
- (f) improve performance in research partnerships by:
- (i) reviewing financial, legal and administrative processes for working with partners; and
 - (ii) seeking contacts with a broader network of partners across all sectors that influence research for health;
- (g) improve communication – both throughout the Secretariat and with Member States, partners and the public – regarding the WHO's involvement in research, submitting regular reports, including reports on the monitoring and evaluation of this strategy.

Expected results

34. Achievement of this goal should produce the results described below:
- WHO Secretariat staff who understand, value and use evidence better in planning, implementing and evaluating programmes and activities, and in setting norms and standards
 - WHO-supported research that systematically adheres to the Organization's code of good research practice and is subject to scientific and, where appropriate, ethical review; guidelines and recommendations that are systematically evidence-based, and articles that are systematically peer reviewed
 - clear communication of WHO's role in research and of the role of research within WHO
 - general recognition that WHO is a credible, evidence-based organization; a leader in supporting or performing high-quality research; a champion of the need for research; and an effective partner in facilitating high-quality research at global, regional and country levels
 - the allocation by WHO of sufficient resources to support core functions necessary for the implementation of the strategy
 - translation of the most up-to-date knowledge and evidence into advice, norms and guidelines by the WHO Secretariat.

PRIORITIES GOAL

35. The priorities goal is to champion research that addresses priority health needs.

The challenge

36. Each country has a responsibility to develop its own agenda for research in order to respond to the health needs important to its population within its own social, political and environmental setting. In addition, there are present and emerging health challenges that must be met through national and cross-country research. Such challenges include preparing for and responding to pandemics, gaining an understanding of the impact of climate change and developing new drugs, vaccines and diagnostics for widespread diseases such as malaria, HIV/AIDS and tuberculosis.

37. However, agreeing on research priorities for improving health and taking action to pursue them remains a significant challenge. The obstacles responsible for this include imbalances in national research priorities, the historical inequity in the distribution of global research funding (with only 10% of financing for global health research allocated to health problems that affect 90% of the world's population) and the difficulty of making the case for financing research in the face of competing priorities.

38. In recent years, however, the mobilization in support of the Millennium Development Goals and the recognition that good health is a foundation of development, have encouraged an impressive upsurge in research for global health. Diverse stakeholders – including governments, civil society, philanthropic bodies and industry – have mobilized significant resources through numerous public-private partnerships and multilateral research initiatives. The Health Assembly has adopted the global strategy and the agreed parts of the action plan on public health, innovation and intellectual property rights. This instrument places emphasis on identifying research and development priorities for tackling diseases of poverty, and identifies the relevant global financing mechanisms.

39. National research capacity needs to be aligned with a complex global environment and the existence of diverse sources of funding for research.

40. Throughout the consultations for this strategy, the Secretariat, working with Member States, donors and key stakeholders, was consistently requested to make greater use of its convening power in order to draw attention to research for health in neglected areas, and to build consensus and catalyse new actions in support of such research.

41. When research capacity is low, WHO is expected to promote collaboration across countries and within regions in order to create a more effective research effort in response to shared health challenges. In such circumstances, as in the past, WHO will develop special programmes for research in order to stimulate activity, leverage resources and encourage innovation.

Actions to achieve the goal

42. Working with Member States and partners, the Secretariat will:

- (a) ensure that mechanisms are in place for synthesizing data on gaps in research relating to current health- and health system-related challenges at national and global levels;
- (b) convene high-level consultations to identify, and build consensus on, the priorities to include in global agendas for research for health and the financing necessary for implementing the relevant activities;
- (c) produce a report every four years on global priorities for research with an assessment of the alignment of financial and human resources with research agendas;

- (d) develop comprehensive research agendas for specific priority areas and develop plans for mobilizing the necessary resources;
- (e) advocate support for research areas, research groups and institutions that are working to close critical gaps in research agendas in support of global research priorities; and
- (f) improve the coherence of WHO's research activities by establishing mechanisms for the periodic review of the portfolio of research agendas, including decision criteria to guide decision-making concerning the initiation, adjustment and winding down of programmes.

Expected results

43. Achievement of this goal should produce the results described below:
- greater awareness of, and action on, research priorities at a national level
 - greater awareness of, and action on, research priorities at regional and global levels
 - improved cooperation and coordination among research funders and other key partners to align global resources so that priority needs for research for health can be met
 - more robust agendas for research on specific priority areas that are facilitated by WHO, and greater coherence and clarity concerning WHO's involvement therein.

CAPACITY GOAL

44. The capacity goal is to support the development of robust national health research systems.

The challenge

45. Robust and vibrant national health research systems in all countries are critical for accelerating the achievement of national and global health goals, namely: better health, improved health equity, and fairer, safer and more efficient health systems.

46. There has long been an understanding of the basic prerequisites for health research systems, namely: clear national research policy, leadership, a capable research workforce, adequate financing, priority-setting mechanisms, strong regulatory frameworks and structures (including ethical oversight), well-equipped research institutions, effective information systems and dissemination plans. Nevertheless, in many countries, particularly low- and middle-income countries, health research systems remain seriously under-resourced and poorly managed, and health information systems are often absent or inadequate.

47. Such deficiencies are evidence of the following: an insufficient appreciation at a political level of the value of research in accelerating health improvement and development; the general absence of coordinated and sustained efforts to build national research systems; and the inability of fragmented research efforts driven by external actors to align themselves with strategies for strengthening national capacities.

48. In consultations for the development of this strategy, the strengthening of national systems for health research and the monitoring of their performance were deemed top priorities for WHO, as part of its key role of providing greater and more visible leadership.

49. WHO needs to foster collaboration between researchers and research institutions in low-, middle- and high-income countries through regional and global networks.

50. The coordination of activities to build research capacity will also need to be improved throughout the Organization. Such activities will need to be aligned with the priorities identified in Member States, and WHO will need to encourage a similar alignment on the part of other actors.

Actions to achieve the goal

51. Working with Member States and partners, the Secretariat will:

- (a) strengthen its advocacy in support of both research and the development of robust national systems for research for health;
- (b) develop tools and guidelines for strengthening national capacity in the four main functions of national systems for research for health (stewardship; financing; creating and sustaining resources; and producing, synthesizing and using knowledge);
- (c) continue to promote the development of the comprehensive systems for health information that are necessary in order to support national research priorities;
- (d) develop and use standardized indicators in order to: enable self-reporting of the performance of national health research systems; monitor global progress in strengthening capacity; and evaluate the effectiveness of particular approaches to capacity-building;
- (e) facilitate technical assistance to support the strengthening of national systems for health research;
- (f) build institutional capacity to report and share good practice, by facilitating regional and global networks, and with the involvement of WHO collaborating centres; and
- (g) maximize the impact of efforts in Member States to build research capacity by improving the alignment of such initiatives across WHO's research programmes and activities.

Expected results

52. Achievement of this goal should produce the results described below:

- greater investment in research for health by countries and other actors
- the existence in all countries, especially low- and middle-income ones, of national research strategies that articulate clear research priorities, credible capacity-building programmes, and explicit terms of engagement for external stakeholders
- the alignment of external stakeholders' research investments with national research strategies
- the development and use of WHO guidelines on research capacity-building, including indicators for measuring progress
- progress reports on national research capacity and activities made every two or three years by the Secretariat through WHO's governing bodies and information databases

- networks of researchers and communities of practice that actively exchange experiences and identify good practices in the area of capacity-building for research
- higher-quality, better-coordinated research activities through the alignment with country needs of WHO's efforts to build national research capacity.

STANDARDS GOAL

53. The standards goal is to promote good research practice.

The challenge

54. Setting international norms, standards and guidelines is one of WHO's core functions, and an activity that the Organization is uniquely placed to perform. The norms, standards and guidelines related to research are applied to govern, manage and improve the quality of research; to address inefficiencies in the research process; and to improve access to information. They are essential to maintaining public trust, confidence and participation in research.

55. Member States, international organizations, stakeholders and the public expect WHO to do more to promote best practices in research. There is also an increasing demand for more accountability and transparency in the conduct of research.

56. One challenge is to develop a methodology that is rigorous, systematic and transparent, with clear criteria for deciding when WHO should work on a new standard or guideline, how that standard or guideline should be developed, and which stakeholders need to be involved. Such a methodology will need to accommodate differences in social and cultural contexts while protecting the rights and welfare of all participants in the research process.

57. Another challenge is to improve the implementation of, and compliance with, existing research standards. The standards concerned include those related to ethics, ethics review committees and clinical trial registration, and laboratory biosafety and biosecurity. Although WHO cannot enforce compliance with standards (except, where applicable, for its own staff), it has an influential role to play in accelerating progress towards the development and adoption of global standards for best practices in research.

58. There is also a need to establish acceptable criteria for the use, for example in the development of guidelines, of evidence that could not be generated using conventional research approaches such as randomized trials.

Actions to achieve the goal

59. Working with Member States and partners, the Secretariat will:

- (a) develop a systematic method for selecting, developing, adopting and evaluating new standards and norms in line with priorities in research for health;
- (b) develop, in line with the guiding principles of this strategy, norms and standards for best practice in the management of research to cover, for example: ethical and expert review and the accreditation of ethical review committees; the reporting of research findings; the sharing of research data, tools and materials; the registration of clinical trials; and the use of evidence in the development of policy, practice and products;

(c) continue to facilitate the development of, and set standards for, publicly accessible registries of clinical trials; and

(d) engage in technical cooperation with Member States in order to enable them to adapt and implement norms and standards for research, and monitor subsequent adherence and compliance.

Expected results

60. Achievement of this goal should produce the results described below:

- strengthened public support for and trust in health and medical research
- implementation by WHO of an improved method for selecting, developing, adopting and evaluating norms and standards related to research
- improved quality, efficiency, transparency, accountability and equity in the research process as a result of greater awareness, acceptance and implementation of standards for the management of research, and compliance therewith
- improved acceptance of, and compliance with, ethical principles in the conduct of research; and the establishment of standards for accreditation of ethics committees
- adoption by all countries of the registration of clinical trials according to WHO standards.

TRANSLATION GOAL

61. The translation goal is to strengthen links between research, policy and practice.

The challenge

62. Consultations for the development of this strategy revealed both the extent to which evidence fails to inform policy and practice, and the degree to which the research agenda fails to respond to policy needs. Referred to as “research translation”, the dynamic interface that links research with policy, practice and product development is increasingly seen as a priority area for research. In addition, new and improved methods are required for communicating health information and evidence effectively to different target audiences across multiple sectors, levels and languages.

63. A significant barrier to achieving this goal is the global inequality of access – in respect of research – to data, tools, materials and literature, which may arise due to restrictions placed on their reuse through the application of copyright and intellectual property. There are various standards that exist for information systems and interoperability but few that are consistently applied in the area of public health informatics.

64. WHO, with its reach into countries and contacts with researchers, policy-makers, practitioners and civil society, can play a unique role in advocating for greater resources in support of research into this knowledge interface. WHO needs to facilitate access to quality data, consolidated evidence and authoritative health information and guidelines in order to support the dialogue between policy-makers and public-health implementers. One WHO-led initiative, the Evidence-Informed Policy Networks initiative, is beginning to provide an approach to meeting these challenges.

65. WHO has contributed to improvements in this area through initiatives such as the Health InterNetwork Access to Research Initiative and the Reproductive Health Library, through the creation of the International Clinical Trials Registry Platform, and by allowing public access to the Organization's databases. However, access to research continues to be limited by a range of factors – including the lack of standards in health informatics, and problems of affordability and language – and the Organization needs to do more to involve itself fully with the open access movement.

Actions to achieve the goal

66. Working with Member States and partners, the Secretariat will:

- (a) identify promising translation activities through evaluation, and promote their use to support decision-making based on the best available research evidence;
- (b) promote the use of effective models of technology transfer and the evaluation of promising models in order to support the timely creation of new products and services in Member States;
- (c) promote and evaluate platforms for translating research in support of translation capacity and evidence-informed policy-making in Member States;
- (d) work towards the creation of, and compliance with, international standards on health informatics for research;
- (e) develop, strengthen and evaluate mechanisms for the systematic elaboration of evidence summaries and guidance for citizens, patients, clinicians, managers and policy-makers in Member States, ensuring that such mechanisms are adapted for the target audience and regularly updated, and that their impact is evaluated;
- (f) systematically analyse barriers and encourage the creation of mechanisms to promote greater access to research results, or the enhancement of existing ones; and
- (g) adopt and articulate a WHO position on open access to research outputs; and advocate for the following: databanks, repositories and other mechanisms for maximizing the availability of health-related research findings that are freely accessible in the public domain.

Expected results

67. Achievement of this goal should produce the results described below:

- a situation in which decision-makers act as informed consumers of research, using available evidence and knowledge more effectively, creating evidence-informed policy and translating that policy into practice and products
- establishment of institutional mechanisms for recording, and sharing lessons learnt from, research focused on the demand for research and the way evidence is used in policy and practice at country level
- performance of research activities in order to understand the translation of evidence into policy and practice and the recognition of the important contribution that such research can make to research for health

- creation and broad application of internationally agreed standards for the collection, storing and sharing of health informatics/tools and data
- establishment of comprehensive repositories that include WHO's research literature that are well stocked, regularly updated and well used
- development of existing repositories of systematic reviews, or the establishment of new ones, in order to meet the priority health needs of low- and middle-income countries
- easy access on the part of both producers and users of research to reliable, relevant, appropriate and timely information that is provided in a format and language they understand
- researchers who are more responsive to the demand side, including to the health-related research questions of policy-makers (in health and other sectors), practitioners and civil society
- a more prominent role played by WHO in identifying effective health interventions and strategies, and in promoting their implementation in Member States.

Table 1. Summary of outputs for the WHO strategy on research for health

<p>Biennial report to the Health Assembly, indicating:</p> <ul style="list-style-type: none"> – progress in implementing and evaluating the research strategy and related expenditures (Organization goal)¹ – global progress in strengthening national health research systems as measured using standardized indicators at the country level (priorities goal) – the adaptation/adoption of norms and standards by Member States and the results of audits examining adherence to them (standards goal)
<p>Biennial report to the Director-General, indicating:</p> <ul style="list-style-type: none"> – the processes, coverage and impact of: <ul style="list-style-type: none"> • WHO's revised recruitment procedures and incentives, and the Organization's training programme on research and research use (Organization goal) • WHO's ethical review committees (standards goal) • WHO's guideline review committee (standards goal) • WHO's programme review committee (Organization goal) – implementation of WHO's code of good research practice, including the results of periodic audits of WHO research practices (Organization goal) – whether, and if so, by what means, improvements have been made in the mechanisms by which WHO acts as a research partner (Organization goal) – research agendas with which WHO is directly involved, or for which it is acting as an advocate, their continued appropriateness for WHO, and their coherence as a whole within WHO (priorities goal)

¹ The goal to which the output is most closely related is indicated in brackets.

<ul style="list-style-type: none"> – WHO’s advocacy efforts related to national health research systems (capacity goal) – the number of country cooperation strategies that involve multi-partner technical cooperation to support the strengthening of national health research systems (capacity goal) – alignments across the efforts to build research capacity with which WHO is affiliated (capacity goal)
<p>Norms and standards</p> <ul style="list-style-type: none"> – Norms and standards for research (standards goal) – WHO’s code of good research practice (Organization goal) – Guidelines for building national capacity in respect of the four main functions of national health research systems (capacity goal)
<p>Public reports and resources</p> <ul style="list-style-type: none"> – Public report every four years (co-published with partners) on global research priorities, comprehensive research agendas for each priority, and the alignment of financial and human resources with these agendas (priorities goal) – Biennial public report on research at WHO (Organization goal) – Public report on WHO’s position on open access to research outputs and on mechanisms to record research outputs that are not currently being recorded elsewhere (translation goal) – Reports on lessons learnt from efforts to build research capacity, including evaluations of the effectiveness of particular approaches using standardized indicators (capacity goal) – Reports on the lessons learnt from using different interventions to support policy and practice in Member States, based on the best available research evidence, using different models of technology transfer and of research-translation platforms (translation goal) – Publicly accessible research registry for all research with which WHO is affiliated (Organization goal) – Publicly accessible clinical trials registries (standards goal) – Up-to-date, optimally packaged evidence summaries that are context-sensitive, and guidance in areas of public health need (translation goal)

IMPLEMENTATION

68. The Eleventh General Programme of Work 2006–2015 provides the WHO Secretariat, Member States and the international community with a global health agenda that stems from an analysis of the current global health situation. After setting the broader global health agenda, the General Programme of Work then describes WHO’s comparative advantages, its core functions, the main challenges it faces and its priorities for the future. These priorities are further developed in the six-year Medium-term strategic plan 2008–2013, which defines 13 strategic objectives for the Secretariat and Member States.

69. The Secretariat will work with Member States and partners to plan the implementation of the WHO strategy on research for health in support of the Medium-term strategic plan within the Eleventh General Programme of Work.

70. For the regional offices, the WHO strategy on research for health sets out a framework to guide the formulation of future regional research strategies.

71. The implementation plans will be realistic and will define clear roles, responsibilities, resources required, outcomes and impacts within a timetable as indicated in the evaluation framework. The plans will build on the research activities already under way in more than 34 WHO programmes, alliances and networks in support of the strategy's goals.

72. A plan for implementing the strategy will be incorporated into the Organization's operational arrangements and workplans and, in discussion with Member States, integrated into country cooperation strategies.

73. A report on progress will be submitted to the Health Assembly on a biennial basis, with the first report scheduled for 2012.

CRITICAL ISSUES IN IMPLEMENTATION

Governance within WHO

74. In order to ensure successful implementation of the strategy, the Organization will need to develop appropriate mechanisms for improving strategic and operational efficiency across the WHO's portfolio of research activities. One possible mechanism would involve the creation of thematic groups working across the Organization in areas such as research capacity-building and knowledge management. Such new mechanisms will be complemented by a thorough review and, where appropriate, revitalization of existing mechanisms. This will include a review of the role of technical and advisory committees, and a possible reconsideration of the role of ACHR, both globally and in the regions.

Working with partners

75. In implementing the strategy, the Secretariat will also need to collaborate effectively with the dedicated research partnerships to which WHO is linked, but which are characterized by independent governance. The partnerships concerned include the following: the Alliance for Health Policy and Systems Research; the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction; the Initiative for Vaccine Research; the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases; the Council on Health Research for Development; and the Global Forum for Health Research. During the implementation process, the value of providing such partnerships with a governance structure that is more aligned, or even shared, with that of the WHO research strategy will be examined; modifications will be made to existing relationships in line with the actions for achieving specific goals.

76. In addition to collaborating with existing partnerships, in implementing the new strategy WHO is expected to work more effectively with key research partners, including industry, civil society, foundations and academia.

Staffing

77. The strategy's success will be largely contingent upon the efforts of WHO technical staff across the Organization. The organizational goal of the strategy provides several recommendations related to improving the research competencies of WHO staff through strengthened support for research, continued learning and changes to the recruitment and evaluation processes as appropriate. Particular attention will need to be paid to identifying the appropriate response for staff at country level. Once

implemented, the code of good research practice will provide a common approach and a set of minimum standards for the research activities of staff wherever they are working. Staff will also be needed for ensuring the effective performance of functions related to cross-cutting thematic groups, ethical and guidelines review, standard setting and communications.

Funding

78. About 80% of the budget for conducting or commissioning research directed through programmes at headquarters (about US\$ 200 million per biennium) is financed through voluntary contributions. The WHO strategy on research for health aims to improve the quality of research outputs by influencing the way in which these resources are spent, rather than by increasing the level of financing.

79. Nevertheless, implementation of this strategy (and of the global strategy and plan of action on public health, innovation and intellectual property) requires an adequately resourced central secretariat responsible for, among other things, cross-cutting themes, communications and evaluation. The funding of the secretariat's activities will require core budget support as funds from either the specific research activities of WHO departments or from voluntary contributions are unlikely to be available. The amount of money to support the secretariat function is modest, representing less than 5% of total research expenditure per biennium. Resources for these core functions will be fully budgeted in the Programme budget 2010–2011.

EVALUATION

Overview

80. Evaluation is an integral part of the WHO strategy on research for health, and an evaluation framework has been developed in order to provide an impact-focused approach for assessing the achievement of the strategy's vision, mission and goals. A report providing details of the framework is available upon request.

81. More specifically, the framework will provide an approach for:

- monitoring implementation of the elements of the research strategy
- evaluating the impact of the changes brought about by implementation of the strategy.

82. The evaluation framework for the WHO strategy on research for health covers both its implementation and its constituent elements, namely, the principles, goals, actions and expected results.

83. The framework has been developed in line with best practices in evaluation; it will:

- be focused on the shared goals and activities of the Secretariat, Member States and partners, as outlined by the research strategy
- give a balanced picture of progress towards realizing the shared vision for the Secretariat, Member States and partners
- be efficient, utilizing existing indicators and mechanisms wherever possible to minimize the reporting burdens of the Secretariat, Member States and partners.

Structure of the evaluation framework

84. The evaluation framework organizes the elements of the WHO strategy on research for health, into inputs/activities, outputs, outcomes and impacts (known as a “logic model”); it also defines indicators to be tracked for each of these components (see below).

85. Although the strategy’s ultimate impact should be improvements in health and health equity (such as those articulated in the Millennium Development Goals), identifying the contribution of research for health generally, and of the strategy in particular, in achieving wider health impacts represents a major challenge. Given the difficulties associated with predicting circumstances in which case studies of health impact would be feasible, the evaluation framework model focuses on impacts that can be evaluated prospectively. The framework can be expanded further to include new indicators of health impact after the implementation phase has started.

Monitoring progress

86. One or more indicators have been developed for each input/activity, output, outcome and impact. Table 2 provides a list of indicators, which is for illustrative purposes only.¹

Table 2. List of indicators

<p>Impact</p> <ul style="list-style-type: none"> – Percentage of priority health needs for which up-to-date systematic reviews of the research literature were made available within one year of the need being identified (priorities goal) – Percentage of a random sample of clinicians in Member States who achieve a nationally defined target for adherence to select high-quality, locally applicable recommendations (translation goal)
<p>Outcomes</p> <ul style="list-style-type: none"> – Percentage, within a random sample, of WHO’s guidelines that are aligned with the best available research evidence (Organization goal) – Percentage of Member States (specifically, their principal delegates at the Health Assembly) that report general satisfaction with the nature of technical cooperation received in support of their national health research system (capacity goal)
<p>Outputs</p> <ul style="list-style-type: none"> – Biennial report on progress in strengthening national health research systems submitted to the Health Assembly (capacity goal) – Norms and standards for research published (standards goal)
<p>Inputs/activities</p> <ul style="list-style-type: none"> – At least 5% of WHO’s combined core and voluntary budgets allocated in support of research at WHO, including dedicated funds for the implementation and evaluation of the research strategy in the current biennium (Organization goal) – Percentage of Member States whose priority-setting processes have been drawn on to inform priorities in research for health (priorities goal)

¹ A full list of indicators will be provided in the document presenting the full evaluation framework.

87. Although indicators available through existing mechanisms have been identified wherever appropriate, new indicators to improve monitoring of selected elements of the research for health agenda have been proposed, where necessary. These new indicators generally concern outcome- and impact-related measures, which are directly linked to the goals of the strategy. A full description of these indicators and proposed mechanisms for monitoring implementation is presented separately in the full evaluation framework.

88. As suggested by the grouping of outputs in Table 1 above, the proposed reporting structures are of four types: governance-related indicators (to be compiled into a biennial report to the Health Assembly); management-related indicators (to be compiled into a biennial report to the Director-General); indicators for norms and standards and indicators for other public reports and resources. All reports will be publicly available on WHO's web site.

ANNEX 5

WHO guiding principles on human cell, tissue and organ transplantation¹

[EB124/15, Annex – 20 November 2008]

PREAMBLE

1. As the Director-General's report to the Executive Board at its Seventy-ninth session pointed out,² human organ transplantation began with a series of experimental studies at the beginning of the twentieth century. The report drew attention to some of the major clinical and scientific advances in the field since Alexis Carrel was awarded the Nobel Prize in 1912 for his pioneering work. Surgical transplantation of human organs from deceased, as well as living, donors to sick and dying patients began after the Second World War. Over the past 50 years, the transplantation of human organs, tissues and cells has become a worldwide practice which has extended, and greatly enhanced the quality of, hundreds of thousands of lives. Continuous improvements in medical technology, particularly in relation to organ and tissue rejection, have led to an increase in the demand for organs and tissues, which has always exceeded supply despite substantial expansion in deceased organ donation as well as greater reliance on donation from living persons in recent years.
2. The shortage of available organs has not only prompted many countries to develop procedures and systems to increase supply but has also stimulated commercial traffic in human organs, particularly from living donors who are unrelated to recipients. The evidence of such commerce, along with the related traffic in human beings, has become clearer in recent decades. Moreover, the growing ease of international communication and travel has led many patients to travel abroad to medical centres that advertise their ability to perform transplants and to supply donor organs for a single, inclusive charge.
3. Resolutions WHA40.13 and WHA42.5 first expressed the Health Assembly's concern over commercial trade in organs and the need for global standards for transplantation. Based on a process of consultation undertaken by the Secretariat, the Health Assembly then endorsed the WHO Guiding Principles on Human Organ Transplantation in resolution WHA44.25. Over the past 17 years the Guiding Principles have greatly influenced professional codes and practices as well as legislation around the world. In the light of changes in practices and attitudes regarding organ and tissue transplantation, the Fifty-seventh World Health Assembly in resolution WHA57.18 requested the Director-General, inter alia, "to continue examining and collecting global data on the practices, safety,

¹ See resolution EB124.R13. The draft update of the official WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation, contained in document EB123/5, was noted by the Executive Board at its 123rd session on 26 May 2008. This version reflects a modification requested by the Board at that session; and was considered by the Board at its 124th session. The word "narrow" is now used instead of "rare" in Guiding Principle 4. Further, the wording of last clause of Guiding Principle 11 has been clarified.

² Document EB79/8.

quality, efficacy and epidemiology of allogeneic transplantation and on ethical issues, including living donation, in order to update the Guiding Principles on Human Organ Transplantation”.

4. The following Guiding Principles are intended to provide an orderly, ethical and acceptable framework for the acquisition and transplantation of human cells, tissues and organs for therapeutic purposes. Each jurisdiction will determine the means of implementing the Guiding Principles. They preserve the essential points of the 1991 version while incorporating new provisions in response to current trends in transplantation, particularly organ transplants from living donors and the increasing use of human cells and tissues. The Guiding Principles do not apply to transplantation of gametes, ovarian or testicular tissue, or embryos for reproductive purposes, or to blood or blood constituents collected for transfusion purposes.

Cells, tissues and organs may be removed from deceased and living persons for the purpose of transplantation, only in accordance with the following Guiding Principles.

Guiding Principle 1

Cells, tissues and organs may be removed from the bodies of deceased persons for the purpose of transplantation if:

- (a) any consent required by law is obtained, and
- (b) there is no reason to believe that the deceased person objected to such removal.

Commentary on Guiding Principle 1

Consent is the ethical cornerstone of all medical interventions. National authorities are responsible for defining the process of obtaining and recording consent for cell, tissue and organ donation in the light of international ethical standards, the manner in which organ procurement is organized in their country, and the practical role of consent as a safeguard against abuses and safety breaches.

Whether consent to procure organs and tissues from deceased persons is “explicit” or “presumed” depends upon each country’s legal system as well as social, medical and cultural traditions, including the manner in which families are involved in decision-making about health care generally. Under both systems any valid indication of deceased persons’ opposition to posthumous removal of their cells, tissues or organs will prevent such removal.

Under a regime of explicit consent – sometimes referred to as “opting in” – cells, tissues or organs may be removed from a deceased person if the person had expressly consented to such removal during his or her lifetime; depending upon domestic law, such consent may be made orally or recorded on a donor card, driver’s license or identity card or in the medical record or a donor registry. When the deceased has neither consented nor clearly expressed opposition to organ removal, permission should be obtained from a legally specified surrogate, usually a family member.

The alternative, presumed consent system – termed “opting (or contracting) out” – permits material to be removed from the body of a deceased person for transplantation and, in some countries, for anatomical study or research, unless the person had expressed his or her opposition before death by filing an objection with an identified office, or an informed party reports that the deceased definitely

voiced an objection to donation. Given the ethical importance of consent, such a system should ensure that people are fully informed about the policy and are provided with an easy means to opt out.

Although expressed consent is not required in an opting-out system before removal of the cells, tissues or organs of a deceased person who had not objected while still alive, procurement programmes may be reluctant to proceed if the relatives personally oppose the donation; likewise, in opting-in systems, programmes typically seek permission from the family even when the deceased gave pre-mortem consent. Programmes are more able to rely on the deceased's explicit or presumed consent, without seeking further permission from family members, when the public's understanding and acceptance of the process of donating cells, tissues and organs is deep-seated and unambiguous. Even when permission is not sought from relatives, donor programmes need to review the deceased's medical and behavioural history with family members who knew him or her well, since accurate information about donors helps to increase the safety of transplantation.

For tissue donation, which entails slightly less challenging time constraints, it is recommended always to seek the approval of the next of kin. An important point to be addressed is the manner in which the appearance of the deceased's body will be restored after the tissues are removed.

Guiding Principle 2

Physicians determining that a potential donor has died should not be directly involved in cell, tissue or organ removal from the donor or subsequent transplantation procedures; nor should they be responsible for the care of any intended recipient of such cells, tissues and organs.

Commentary on Guiding Principle 2

This Principle is designed to avoid the conflict of interest that would arise were the physician or physicians determining the death of a potential donor to be responsible in addition for the care of other patients whose welfare depended on cells, tissues or organs transplanted from that donor.

National authorities will set out the legal standards for determining that death has occurred and specify how the criteria and process for determining death will be formulated and applied.

Guiding Principle 3

Donation from deceased persons should be developed to its maximum therapeutic potential, but adult living persons may donate organs as permitted by domestic regulations. In general living donors should be genetically, legally or emotionally related to their recipients.

Live donations are acceptable when the donor's informed and voluntary consent is obtained, when professional care of donors is ensured and follow-up is well organized, and when selection criteria for donors are scrupulously applied and monitored. Live donors should be informed of the probable risks, benefits and consequences of donation in a complete and understandable fashion; they should be legally competent and capable of weighing the information; and they should be acting willingly, free of any undue influence or coercion.

Commentary on Guiding Principle 3

The Principle emphasizes the importance both of taking the legal and logistical steps needed to develop deceased donor programmes where these do not exist and of making existing programmes as effective and efficient as possible.

While favouring the maximal development of transplant programmes that avoid the inherent risks to live donors, the Principle also sets forth basic conditions for live donation. A genetic relationship between donor and recipient may be therapeutically advantageous and can provide reassurance that the donor is motivated by genuine concern for the recipient, as can a legal relationship (such as that between spouses). Many altruistic donations also originate from emotionally related donors, though the strength of a claimed connection may be difficult to evaluate. Donations by unrelated donors have been a source of concern, though some such cases are unexceptionable, such as in hematopoietic stem cell transplantation (where a wide donor pool is therapeutically advisable) or when an exchange of kidneys is made because the donors are not immunologically well matched with the recipients to whom they are related.

With live donation, particularly by unrelated donors, psychosocial evaluation is needed to guard against coercion of the donor or the commercialism banned by Principle 5. The national health authority should ensure that the evaluation is carried out by an appropriately qualified, independent party. By assessing the donor's motivation and the donor's and recipient's expectations regarding outcomes, such evaluations may help identify – and avert – donations that are forced or are actually paid transactions.

The Principle underscores the necessity of genuine and well-informed choice, which requires full, objective, and locally relevant information and excludes vulnerable persons who are incapable of fulfilling the requirements for voluntary and knowledgeable consent. Voluntary consent also implies that adequate provisions exist for withdrawal of consent up until medical interventions on the recipient have reached the point where the recipient would be in acute danger if the transplant did not proceed. This should be communicated at the time of consent.

Finally, this Principle stresses the importance of protecting the health of living donors during the process of selection, donation, and necessary aftercare to ensure that the potential untoward consequences of the donation are unlikely to disadvantage the remainder of the donor's life. Care for the donor should match care for the recipient, and health authorities have the same responsibility for the welfare of both.

Guiding Principle 4

No cells, tissues or organs should be removed from the body of a living minor for the purpose of transplantation other than narrow exceptions allowed under national law. Specific measures should be in place to protect the minor and, wherever possible the minor's assent should be obtained before donation. What is applicable to minors also applies to any legally incompetent person.

Commentary on Guiding Principle 4

This Principle states a general prohibition on the removal of cells, tissues or organs from legal minors for transplantation. The major exceptions that may be authorized are familial donation of regenerative cells (when a therapeutically comparable adult donor is not available) and kidney transplants between identical twins (where avoiding immunosuppression represents a benefit to the recipient adequate to justify the exception, in the absence of a genetic disorder that could adversely affect the donor in the future).

While the permission of the parent(s) or the legal guardian for organ removal is usually sufficient, they may have a conflict of interest if they are responsible for the welfare of the intended recipient. In such cases, review and approval by an independent body, such as a court or other competent authority, should be required. In any event, a minor's objection to making a donation should prevail over the permission provided by any other party. The professional counselling provided to potential living donors in order to assess, and when needed, address any pressure in the decision to donate, is especially important for minor donors.

Guiding Principle 5

Cells, tissues and organs should only be donated freely, without any monetary payment or other reward of monetary value. Purchasing, or offering to purchase, cells, tissues or organs for transplantation, or their sale by living persons or by the next of kin for deceased persons, should be banned.

The prohibition on sale or purchase of cells, tissues and organs does not preclude reimbursing reasonable and verifiable expenses incurred by the donor, including loss of income, or paying the costs of recovering, processing, preserving and supplying human cells, tissues or organs for transplantation.

Commentary on Guiding Principle 5

Payment for cells, tissues and organs is likely to take unfair advantage of the poorest and most vulnerable groups, undermines altruistic donation, and leads to profiteering and human trafficking. Such payment conveys the idea that some persons lack dignity, that they are mere objects to be used by others.

Besides preventing trafficking in human materials, this Principle aims to affirm the special merit of donating human materials to save and enhance life. However, it allows for circumstances where it is customary to provide donors with tokens of gratitude that cannot be assigned a value in monetary terms. National law should ensure that any gifts or rewards are not, in fact, disguised forms of payment for donated cells, tissues or organs. Incentives in the form of "rewards" with monetary value that can be transferred to third parties are not different from monetary payments.

While the worst abuses involve living organ donors, dangers also arise when payments for cells, tissues and organs are made to next of kin of deceased persons, to vendors or brokers, or to institutions (such as mortuaries) having charge of dead bodies. Financial returns to such parties should be forbidden.

This Principle permits compensation for the costs of making donations (including medical expenses and lost earnings for live donors), lest they operate as a disincentive to donation. The need to cover legitimate costs of procurement and of ensuring the safety, quality and efficacy of human cell and tissue products and organs for transplantation is also accepted.

Incentives that encompass essential items which donors would otherwise be unable to afford, such as medical care or health insurance coverage, raise concerns. Access to those services should not be subject to purchase in exchange for body parts. However, free periodic medical assessments related to the donation and insurance for death or complications that arise from the donation may legitimately be provided to living donors.

Health authorities should promote donation motivated by the need of the recipient and the benefit for the community. Any measures to encourage donation should respect the dignity of the donor and foster societal recognition of the altruistic nature of cell, tissue and organ donation. In any event, all practices to encourage the procurement of cells, tissues and organs for transplantation should be defined explicitly by health authorities in a transparent fashion.

National legal frameworks should address each country's particular circumstances because the risks to donors and recipients vary. Each jurisdiction will determine the details and method of the prohibitions it will use, including sanctions which may encompass joint action with other countries. The ban on paying for cells, tissues and organs should apply to all individuals, including transplant recipients who attempt to circumvent domestic regulations by travelling to locales where prohibitions on commercialization are not enforced.

Guiding Principle 6

Promotion of altruistic donation of human cells, tissues or organs by means of advertisement or public appeal may be undertaken in accordance with domestic regulation.

Advertising the need for or availability of cells, tissues or organs, with a view to offering or seeking payment to individuals for their cells, tissues or organs, or, to the next of kin, where the individual is deceased, should be prohibited. Brokering that involves payment to such individuals or to third parties should also be prohibited.

Commentary on Guiding Principle 6

This Principle does not affect general advertisements or public appeals to encourage altruistic donation of human cells, tissues or organs, provided that they do not subvert legally established systems of organ allocation. Instead, it aims to prohibit commercial solicitations, which include offering to pay individuals, the next of kin of deceased persons, or other parties in possession (such as undertakers), for cells, tissues or organs; it targets brokers and other intermediaries as well as direct purchasers.

Guiding Principle 7

Physicians and other health professionals should not engage in transplantation procedures, and health insurers and other payers should not cover such procedures, if the cells, tissues or organs concerned have been obtained through exploitation or coercion of, or payment to, the donor or the next of kin of a deceased donor.

Commentary on Guiding Principle 7

Health-care professionals should only proceed with the removal, intermediate management or implantation of cells, tissues or organs when donations are unpaid and truly voluntary. (In the case of live donors, a psychosocial evaluation of the donor is usually indicated, as described in Guiding Principle 3). Failing to ensure that the person consenting to the donation has not been paid, coerced or exploited breaches professional obligations and should be sanctioned by the relevant professional organizations and government licensing or regulatory authorities.

Physicians and health-care facilities should also not refer patients to transplant facilities in their own or other countries that make use of cells, tissues or organs obtained through payments to donors, their families or other vendors or brokers; nor may they seek or accept payment for doing so. Post-transplant care may be provided to patients who have undergone transplantation at such facilities, but physicians who decline to provide such care should not face professional sanctions for such refusals, provided that they refer such patients elsewhere.

Health insurers and other payers should reinforce adherence to high ethical standards by refusing to pay for transplants that violate the Guiding Principles.

Guiding Principle 8

All health-care facilities and professionals involved in cell, tissue or organ procurement and transplantation procedures should be prohibited from receiving any payment that exceeds the justifiable fee for the services rendered.

Commentary on Guiding Principle 8

This provision reinforces Guiding Principles 5 and 7 by forbidding profiteering in cell, tissue and organ recovery and implantation. Health authorities should monitor the fees charged for transplantation services to ensure that they are not disguised charges for the cells, tissues or organs themselves. All persons and facilities involved should be accountable for all payments for transplantation services. A medical or other health-care practitioner uncertain whether a fee is justifiable should seek the opinion of an appropriate licensing or disciplinary authority before proposing or levying the fee. Fees charged for similar services may be used as a reference.

Guiding Principle 9

The allocation of organs, cells and tissues should be guided by clinical criteria and ethical norms, not financial or other considerations. Allocation rules, defined by appropriately constituted committees, should be equitable, externally justified, and transparent.

Commentary on Guiding Principle 9

Where donation rates do not meet clinical demand, allocation criteria should be defined at national or subregional level by a committee that includes experts in the relevant medical specialities, bioethics and public health. Such multidisciplinary is important to ensure that allocation takes into account not only medical factors but also community values and general ethical rules. The criteria for distributing cells, tissues and organs should accord with human rights and, in particular, should not be based on a recipient's gender, race, religion, economic or other conditions.

This Principle implies that the cost of transplantation and follow-up, including immunosuppressive treatment where applicable, should be affordable to all patients concerned – that is, no recipient should be excluded solely for financial reasons.

The concept of transparency is not exclusive to the allocation process but is central to all aspects of transplantation (as is discussed in the commentary on Guiding Principle 11, below).

Guiding Principle 10

High-quality, safe and efficacious procedures are essential for donors and recipients alike. The long-term outcomes of cell, tissue and organ donation and transplantation should be assessed for the living donor as well as the recipient in order to document benefit and harm.

The level of safety, efficacy and quality of human cells, tissues and organs for transplantation, as health products of an exceptional nature, must be maintained and optimized on an ongoing basis. This requires implementation of quality systems including traceability and vigilance, with adverse events and reactions reported, both nationally and for exported human products.

Commentary on Guiding Principle 10

Optimizing the outcome of cell, tissue and organ transplantation entails a rules-based process that encompasses clinical interventions and *ex vivo* procedures from donor selection through long-term follow-up. Under the oversight of national health authorities, transplant programmes should monitor both donors and recipients to ensure that they receive appropriate care, including information regarding the transplantation team responsible for their care.

Evaluation of information regarding the long-term risks and benefits is essential to the consent process and for adequately balancing the interests of donors as well as recipients. The benefits to both must outweigh the risks associated with the donation and transplantation. Donors should not be permitted to donate in clinically hopeless situations.

Donation and transplant programmes are encouraged to participate in national and/or international transplant registries. All deviations from accepted processes that could elevate the risk to recipients or donors, as well as any untoward consequences of donation or transplantation, should be reported to and analysed by responsible health authorities.

Transplantation of human material which does not involve maintenance treatment may not require active, long-term follow-up, though traceability should be ensured for the anticipated lifetime of the donor and the recipient. Internationally agreed means of coding to identify tissues and cells used in transplantation are essential for full traceability.

Guiding Principle 11

<p>The organization and execution of donation and transplantation activities, as well as their clinical results, must be transparent and open to scrutiny, while ensuring that the personal anonymity and privacy of donors and recipients are always protected.</p>
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Commentary on Guiding Principle 11

Transparency can be summarized as maintaining public access to regularly updated comprehensive data on processes, in particular allocation, transplant activities and outcomes for both recipients and living donors, as well as data on organization, budgets and funding. Such transparency is not inconsistent with shielding from public access information that could identify individual donors or recipients while still respecting the necessity of traceability recognized in Principle 10. The objective of the system should be not only to maximize the availability of data for scholarly study and governmental oversight but also to identify risks – and facilitate their correction – in order to minimize harm to donors or recipients

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ANNEX 6

Confirmation of amendments to Staff Rules and Staff Regulations¹

[EB124/34 – 6 January 2009]

1. Amendments to the Staff Rules made by the Director-General are submitted for confirmation by the Executive Board in accordance with Staff Regulations 12.2.²
2. Proposed amendments to the Staff Regulations in accordance with Staff Regulation 12.1² were submitted to the Executive Board, which was requested to recommend their adoption to the Sixty-second World Health Assembly.
3. The amendments to the Staff Rules described in section I of this document stem from decisions expected to be taken by the United Nations General Assembly at its Sixty-third session, on the basis of recommendations made by the International Civil Service Commission in its annual report for 2008.³ Should the United Nations General Assembly not approve the Commission's recommendations, an addendum to this document will be issued.
4. The amendments to the Staff Rules and the proposed amendments to the Staff Regulations described in section II of this document are considered necessary in the light of experience and in the interests of good human resources management.
5. The financial implications of the amendments in the biennium 2008–2009 include negligible additional costs under the regular budget, which will be met from the appropriate allocations established for each of the regions and for global and interregional activities, and from extrabudgetary sources of funds.
6. The amendments to the Staff Rules are set out in [Appendix 1 and Attachments 1 and 2] and the proposed amendments to the Staff Regulations are set out in [Appendix 2].

¹ See resolutions EB124.R14 and EB124.R15.

² *Basic documents*, 46th ed., Geneva, World Health Organization, 2007.

³ *Official records of the General Assembly, Sixty-third session, Supplement No.30 (A/63/30)*.

I. AMENDMENTS CONSIDERED NECESSARY IN THE LIGHT OF DECISIONS EXPECTED TO BE TAKEN BY THE UNITED NATIONS GENERAL ASSEMBLY AT ITS SIXTY-THIRD SESSION ON THE BASIS OF RECOMMENDATIONS OF THE INTERNATIONAL CIVIL SERVICE COMMISSION

Remuneration of staff in the professional and higher categories

7. The Commission recommended to the United Nations General Assembly that the current base/floor salary scale for the professional and higher categories should be increased by 2.33% through the standard consolidation method of increasing base salary and commensurately reducing post adjustment multiplier points (i.e. on a no loss/no gain basis) with effect from 1 January 2009.

8. Subject to the decision of the United Nations General Assembly in respect of the recommendation in paragraph 7 above, amendments to Appendix 1 of the Staff Rules have been prepared accordingly and are attached at [Attachment 1].

Salaries of staff in ungraded posts, and of the Director-General

9. Subject to the decision of the United Nations General Assembly in respect of the recommendation in paragraph 7 above, the Director-General proposes, in accordance with Staff Regulation 3.1, that the Executive Board may wish to recommend to the Sixty-second World Health Assembly modifications in the salaries of Assistant Directors-General and Regional Directors. Thus, as from 1 January 2009, the gross salary for Assistant Directors-General and Regional Directors would be US\$ 177 032 per annum, and the net salary US\$ 128 071 (dependency rate) or US\$ 115 973 (single rate).

10. Based on the adjustments to salaries described above, the gross salary to be authorized by the Health Assembly for the Deputy Director-General would be, as from 1 January 2009, US\$ 194 820 per annum with a corresponding net salary of US\$ 139 633 (dependency rate) or US\$ 125 663 (single rate).

11. The salary adjustments described above would imply similar modifications to the salary of the Director-General. The salary to be authorized by the Health Assembly, as of 1 January 2009, would therefore be US\$ 239 632 per annum gross, US\$ 168 761 net (dependency rate) or US\$ 150 079 net (single rate).

Review of the level of the education grant

12. The Commission recommended to the United Nations General Assembly that:

(a) for Austria, Belgium, Italy, the Netherlands, Spain, Sweden, Switzerland, the United Kingdom of Great Britain and Northern Ireland, the United States of America and the United States dollar area outside the United States, the maximum admissible expenses and the maximum education grant should be adjusted as shown in annex II, table 1 of its report for 2008;

(b) for Denmark, France (subject to subparagraph (f) below), Germany, Ireland and Japan, the maximum admissible expenses and the maximum education grant should remain at the current levels shown in annex II, table 2 of its report for 2008;

- (c) the separate zone of Finland should be discontinued and the education grant claims for that country should be included in the United States dollar area outside the United States;
- (d) the special measures for China, Indonesia and the Russian Federation should be maintained;
- (e) special measures should be introduced for Bulgaria and Hungary, which would allow organizations to reimburse 75% of actual expenses up to and not exceeding the maximum expenditure level in force for the United States dollar inside the United States;
- (f) in addition to the list of six institutions in France currently eligible for special measures, a separate maximum admissible expense level equal to that applicable to the United States dollar inside the United States of America should be established for two more schools in France: Ecole Active Bilingue Victor Hugo and Ecole Active Bilingue Jeannine Manuel;
- (g) the flat rates for boarding, taken into account within the maximum admissible educational expenses, and the additional amounts for reimbursement of boarding costs over and above the maximum grant payable to staff members at designated duty stations, should be revised as shown in annex II, table 3, to the Commission's report for 2008;
- (h) the amount of the special education grant for each disabled child should be equal to 100% of the revised amounts of the maximum allowable expenses for the regular grant; and
- (i) all the above measures should be applicable as from the school year in progress on 1 January 2009.

13. Subject to the decision of the United Nations General Assembly in respect of the recommendations in paragraph 12 above, amendments to Appendix 2 to the Staff Rules have been prepared accordingly and are attached at [Attachment 2].

II. AMENDMENTS CONSIDERED NECESSARY IN THE LIGHT OF EXPERIENCE AND IN THE INTERESTS OF GOOD HUMAN RESOURCES MANAGEMENT

Amendments to the Staff Rules

14. **Definitions – dependent child.** Staff Rule 310.5.2 has been amended in order to clarify that, if both parents are members of international organizations applying the common system of salaries and allowances, the children, if determined dependent, will be recognized as dependants of the parent whose annual gross occupational earnings yield the higher amount.
15. This amendment ensures that Staff Rule 310.5.2 reflects the appropriate compensation principles applied within United Nations common system.
16. **Within-grade increases – language incentive.** Staff Rule 550.3 has been amended to clarify that staff in the national professional officer category are eligible to receive the language incentive.

17. **Special education grant travel.** Staff Rule 825 has been amended in the interest of consistency and equality between staff members entitled to education grant travel and staff members entitled to special education grant travel.

Amendments to the Staff Regulations

18. It is proposed that the Sixty-second World Health Assembly be asked to amend Staff Regulation 4.2 to provide that the principles of efficiency, competency and integrity also extend to reassignment of staff as defined in Staff Rule 565.3.

19. Recent jurisprudence of the Administrative Tribunal of ILO has called into question the authority to transfer or reassign staff members without promotion, when it is in the interest of the Organization to do so. Specifically, Staff Regulation 4.3 may now be understood to restrict such actions. In order to ensure the continued ability of the Organization to transfer or reassign staff members without promotion when it is in the interests of the Organization to do so, it is proposed that Staff Regulation 4.3 be amended.

ACTION BY THE EXECUTIVE BOARD

20. [This paragraph contained three draft resolutions, which were adopted at the twelfth meeting as resolutions EB124.R14, EB124.R15 and EB124.R16, respectively.]

APPENDIX 1

TEXT OF AMENDED STAFF RULES

310. DEFINITIONS

.....

310.5.2 a child as defined by the Director-General and for whom the staff member certifies that he provides the main and continuing support, provided that the child is under 18 years of age or, if in full-time attendance at a school or university, under the age of 21 years. Age and school attendance requirements shall not apply if the child is physically or mentally incapacitated for substantial gainful employment either permanently or for a period expected to be of long duration. If both parents are staff members of international organizations applying the common system of salaries and allowances, the children, if determined dependent, shall be recognized as dependants of the parent whose annual gross occupational earnings yield the higher amount;

[No further changes]

.....

550. WITHIN-GRADE INCREASE

.....

550.3 The unit of service time shall be reduced to ten months under Rule 550.2.1 and to twenty months under Rule 550.2.2 in the case of staff members who have demonstrated, by passing a prescribed test, proficiency of a second official language of the Organization. Staff members whose mother tongue is one of the official languages of the Organization must demonstrate proficiency in a second official language. This Rule applies to staff members in the national professional category and in the professional and higher categories except for conference and other short-term service staff appointed under Rule 1320, e.g., translators, editors, revisers and interpreters.

[No further changes]

.....

825. SPECIAL EDUCATION GRANT TRAVEL

The Organization shall, in accordance with terms and conditions determined by the Director-General, pay travel expenses of dependent children in respect of whom staff members are entitled to the special education grant under Rule 355. The provisions of this Rule shall apply to professional and higher category staff not serving in the country of their recognized place of residence, and to staff referred to in Rule 1310.4 recruited outside the local area as well as the country of the official station. They shall not apply to other staff referred to in Rules 1310 and 1330.

[No further changes]

ATTACHMENT 1

Appendix 1 to the Staff Rules

Salary scale for staff in the professional and higher categories: annual gross base salaries and net equivalents after application of staff assessment (in US dollars)¹
(effective 1 January 2009)

	STEP														
<i>Level</i>	<i>I</i>	<i>II</i>	<i>III</i>	<i>IV</i>	<i>V</i>	<i>VI</i>	<i>VII</i>	<i>VIII</i>	<i>IX</i>	<i>X</i>	<i>XI</i>	<i>XII</i>	<i>XIII</i>	<i>XIV</i>	<i>XV</i>
		*	*	*	*	*									
D-2 Gross	145,112	148,187	151,322	154,540	157,757	160,974									
Net D	107,176	109,267	111,359	113,451	115,542	117,633									
Net S	98,461	100,226	101,985	103,707	105,486	107,225									
					*	*	*								
P6/D-1 Gross	132,609	135,310	138,006	140,707	143,409	146,107	148,809	151,578	154,402						
Net D	98,674	100,511	102,344	104,181	106,018	107,853	109,690	111,526	113,361						
Net S	91,206	92,802	94,394	95,982	97,568	99,150	100,725	102,300	103,870						
										*	*	*			
P-5 Gross	109,690	111,987	114,285	116,581	118,879	121,175	123,474	125,771	128,068	130,365	132,662	134,959	137,257		
Net D	83,089	84,651	86,214	87,775	89,338	90,899	92,462	94,024	95,586	97,148	98,710	100,272	101,835		
Net S	77,190	78,578	79,962	81,345	82,726	84,102	85,478	86,851	88,222	89,590	90,956	92,318	93,680		
												*	*	*	
P-4 Gross	89,982	92,075	94,168	96,261	98,356	100,475	102,694	104,909	107,126	109,340	111,559	113,774	115,991	118,209	120,426
Net D	69,287	70,794	72,301	73,808	75,316	76,823	78,332	79,838	81,346	82,851	84,360	85,866	87,374	88,882	90,390
Net S	64,521	65,894	67,266	68,634	70,002	71,369	72,735	74,098	75,460	76,822	78,181	79,540	80,898	82,254	83,609
													*	*	*
P-3 Gross	73,546	75,483	77,424	79,358	81,299	83,235	85,172	87,113	89,050	90,988	92,928	94,863	96,803	98,739	100,716
Net D	57,453	58,848	60,245	61,638	63,035	64,429	65,824	67,221	68,616	70,011	71,408	72,801	74,198	75,592	76,987
Net S	53,629	54,912	56,198	57,480	58,765	60,046	61,328	62,614	63,895	65,178	66,457	67,737	69,014	70,294	71,573
												*			
P-2 Gross	59,908	61,643	63,375	65,110	66,843	68,575	70,310	72,039	73,775	75,510	77,242	78,978			
Net D	47,634	48,883	50,130	51,379	52,627	53,874	55,123	56,368	57,618	58,867	60,114	61,364			
Net S	44,679	45,812	46,941	48,073	49,202	50,334	51,464	52,593	53,722	54,850	55,979	57,107			
P-1 Gross	46,553	48,036	49,514	51,122	52,785	54,450	56,118	57,785	59,447	61,114					
Net D	37,708	38,909	40,106	41,308	42,505	43,704	44,905	46,105	47,302	48,502					
Net S	35,570	36,675	37,781	38,886	39,991	41,095	42,201	43,293	44,379	45,466					

¹ D = Rate applicable to staff members with a dependent spouse or child; S = Rate applicable to staff members with no dependent spouse or child.

* = The normal qualifying period for a within-grade increase between consecutive steps is one year, except at those steps marked with an asterisk, for which a two-year period at the preceding step is required (Staff Rule 550.2).

ATTACHMENT 2

Appendix 2 to the Staff Rules

**Education grant entitlements applicable in cases
where educational expenses are incurred in specified currencies and countries**

(effective school year in progress 1 January 2009)

<i>Country/ currency area</i>	(1) Maximum admissible educational expenses and maximum grant for disabled children	(2) Maximum education grant	(3) Flat rate when boarding not provided	(4) Additional flat rate for boarding (for staff serving at designated duty stations)	(5) Maximum grant for staff members serving at designated duty stations	(6) Maximum admissible educational expenses for attendance (only when flat rate for boarding is paid)
<u>Part A</u>						
Euro						
Austria	16 719	12 539	3 709	5 564	18 103	11 773
Belgium	15 458	11 593	3 452	5 178	16 771	10 855
Finland (deleted see United States dollar outside the United States)	-	-	-	-	-	-
France*	10 263	7 697	2 995	4 493	12 190	6 269
Germany	18 993	14 245	4 179	6 269	20 514	13 421
Ireland	17 045	12 784	2 945	4 417	17 452	12 896
Italy	18 936	14 202	3 128	4 692	18 894	14 765
Luxembourg	15 458	11 593	3 452	5 178	16 771	10 855
Monaco	10 263	7 697	2 995	4 493	12 190	6 269
Netherlands	16 521	12 391	3 844	5 766	18 157	11 396
Spain	15 139	11 354	3 153	4 730	16 094	10 935
Denmark (krone)	108 147	81 110	26 219	39 329	120 439	73 188
Japan (yen)	2 324 131	1 743 098	607 703	911 555	2 654 653	1 513 860
Norway (deleted see United States dollar outside the United States)	-	-	-	-	-	-
Sweden (krona)	157 950	118 462	24 653	36 980	155 442	125 079
Switzerland (Swiss franc)	28 749	21 562	5 458	8 187	29 749	21 472
United Kingdom of Great Britain and Northern Ireland (pound sterling)	22 674	17 005	3 488	5 232	22 237	18 076
<u>Part B</u>						
United States dollar (outside the United States of America)**	19 311	14 484	3 655	5 483	19 967	14 439
<u>Part C</u>						
United States dollar (in the United States) ¹	39 096	29 322	5 777	8 666	37 988	31 393

* Except for the following schools where the US\$ in the US levels will be applied:

1. American School of Paris
2. American University of Paris
3. British School of Paris
4. Ecole Active Bilingue Victor Hugo
5. European Management Lyon Business School
6. International School of Paris
7. Marymount International School, Paris
8. Ecole Active Bilingue Jeannine Manuel

** includes Finland and Norway, which will no longer be tracked as separate zones.

Where educational expenses are incurred in any of the currencies set out in the table above, the maximum applicable amounts are set out in columns (1) to (6) against those currencies. Where educational expenses are incurred in the United States of America, the maximum applicable amounts are set out in columns (1) to (6) against part C above. Where educational

¹ United States dollar in the United States applies, as a special measure, for China, Indonesia, and the Russian Federation. Effective school year in progress on 1 January 2009 special measure also applies for Bulgaria and Hungary.

expenses are not incurred in any of the currencies set out in part A above or in the United States, the maximum applicable amounts are set out in columns (1) to (6) against part B above.

Attendance at an educational institution outside the duty station

(i) Where the educational institution provides board, the amount shall be 75% of the admissible costs of attendance and the costs of board up to the maximum indicated in column (1), with a maximum grant indicated in column (2) per year.

(ii) Where the educational institution does not provide board, the amount shall be a flat sum as indicated in column (3), plus 75% of the admissible costs of attendance up to a maximum grant as indicated in column (2) per year.

Attendance at an educational institution at the duty station

(iii) The amount shall be 75% of the admissible costs of attendance up to the maximum indicated in column (1), with a maximum grant as indicated in column (2) per year.

(iv) Where the grant is payable for the cost of boarding for attendance at an educational institution in the country of the official station but beyond commuting distance from the official station, and when no suitable education facility exists in that area, the amount of the grant shall be calculated at the same rates as specified in (i) or (ii) above.

Staff serving at designated duty stations with inadequate or no education facilities with attendance at an educational institution at the primary or secondary level outside the duty station

(v) Where the educational institution provides board, the amount shall be:

- a. 100% of the costs of board up to the maximum indicated in column (4); and
- b. 75% of the admissible costs of attendance and of any part of the costs of board in excess of the amount indicated in column (4), with a maximum reimbursable amount as indicated in column (5).

(vi) Where the educational institution does not provide board, the amount shall be:

- a. A flat sum for board as indicated in column (4); and
- b. 75% of the admissible costs of attendance, with a maximum reimbursable amount as indicated in column (5).

APPENDIX 2

AMENDMENTS TO THE STAFF REGULATIONS

Existing text	Proposed text
<p>4.</p> <p>...</p> <p>4.2 The paramount consideration in the appointment, transfer or promotion of the staff shall be the necessity of securing the highest standards of efficiency, competence and integrity. Due regard shall be paid to the importance of recruiting and maintaining the staff on as wide a geographical basis as possible.</p>	<p>4.</p> <p>...</p> <p>4.2 The paramount consideration in the appointment, transfer, reassignment or promotion of the staff shall be the necessity of securing the highest standards of efficiency, competence and integrity. Due regard shall be paid to the importance of recruiting and maintaining the staff on as wide a geographical basis as possible.</p> <p>[No further changes]</p>
<p>4.3 Selection of staff members shall be without regard to race, creed or sex. So far as is practicable, selection shall be made on a competitive basis.</p>	<p>4.3 Selection of staff members shall be without regard to race, creed or sex. So far as is practicable, selection shall be made on a competitive basis; however, the foregoing shall not apply to the filling of a position by transfer or reassignment of a staff member without promotion in the interest of the Organization.</p> <p>[No further changes]</p>

ANNEX 7

Financial and administrative implications for the Secretariat of resolutions adopted by the Executive Board

1. Resolution EB124.R4 The grave health situation caused by Israeli military operations in the occupied Palestinian territory, particularly the occupied Gaza Strip

2. Linkage to programme budget

Strategic objective:

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

Organization-wide expected results:

5.2 Norms and standards developed, capacity built and technical support provided to Member States for a timely response to disasters associated with natural hazards and to conflict-related crises.

5.3 Norms and standards developed, capacity built and technical support provided to Member States for assessing needs and for planning and implementing interventions during the transition and recovery phases of conflicts and disasters.

5.6 Effective communications issued, partnerships formed and coordination developed with other organizations in the United Nations system, governments, local and international nongovernmental organizations, academic institutions and professional associations at the country, regional and global levels.

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

Linked with indicators 5.2.1, 5.3.2, 5.6.1 and 5.6.2.

3. Financial implications

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

- US\$ 13.5 million for the acute response period
- US\$ 22 million for the recovery and reconstruction phase
- US\$ 2 million for the implementation of the health cluster.

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

- US\$ 18 million for the biennium 2008–2009.

Costs will be incurred primarily by the WHO Office in the occupied Palestinian territory, but also by the Regional Office for the Eastern Mediterranean and headquarters.

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

- US\$ 900 000 under existing programmed activities for the biennium 2008–2009. The rest will have to be added into the programme as resources become available from special appeals.

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

Through a flash appeal for the Gaza Strip; the revised Consolidated Appeal for the occupied Palestinian Territory 2009; the European Commission's Humanitarian Aid department's contribution for strengthening WHO's work in emergencies.

4. 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 Office for the Eastern Mediterranean and the WHO Office for the occupied Palestinian territory in Jerusalem.

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

- One dedicated health cluster coordinator in the professional category for two years (at US\$ 156 000)
- One dedicated deputy health cluster coordinator in the professional category for two years (at US\$ 376 000)

Assessment and response team deployed for three months (at US\$ 200 000).

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

- Special mission (two weeks)
- Health cluster coordination (two years)
- Response operations (three months)
- Recovery and reconstruction (two years).

1. Resolution EB124.R5 Climate change 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 results:

8.1. Evidence-based assessments made, and norms and guidance 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); technical support provided for the implementation of international environmental agreements and for monitoring progress towards achievement of the Millennium Development Goals.

8.3 Technical assistance and support provided to Member States for strengthening occupational and environmental health policy-making, planning of preventive interventions, service delivery and surveillance.

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, climate change, and altered patterns of consumption and production and to the damaging effect of evolving technologies.

(For the biennium 2010–2011, all activities will take place under the proposed new Organization-wide expected result 8.6, which is specifically concerned with climate change and health.)

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

The intensification of efforts to protect health from climate change is consistent with the expected results under strategic objective 8, and the main elements of the new WHO workplan are represented within the indicators and targets of Organization-wide expected results 8.1, 8.3 and 8.5 for the biennium 2008–2009. The activities in the workplan will be used to define the indicators and associated targets and baselines in the proposed new Organization-wide expected result 8.6 on climate change and health for the biennium 2010–2011.

3. Financial implications

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

The resolution is open-ended. Costs have been estimated for the current biennium and the biennium 2010–2011.

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

Estimated costs for the current biennium are US\$ 6.4 million. Staffing costs are estimated at US\$ 3.4 million, with US\$ 1.5 million at headquarters, and US\$ 1.9 million across all six regional offices. The cost of activities is estimated at US\$ 3 million, with US\$ 1 million at headquarters, and US\$ 2 million in the regional offices.

(For the biennium 2010–2011 estimated costs are US\$ 22.2 million. Staffing costs are estimated at US\$ 12 million, with US\$ 6.3 million at headquarters, and US\$ 5.7 million across all six regional offices. The cost of activities is estimated at US\$ 10.2 million, with US\$ 4.2 million at headquarters, and US\$ 6 million in the regional offices.)

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

The total estimated cost for the current biennium can be subsumed under the Programme budget 2008–2009, which was planned taking into account the increasing concern over the health effects of climate change.

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

Not applicable.

4. Administrative implications

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

The focus of the global workplan is Organization-wide, with activities at global, regional and country levels. The role of headquarters will be to set standards, provide guidance and coordinate and support implementation.

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

From the beginning of 2009, it is estimated that four additional staff members (full-time equivalent) will be needed at headquarters (skills profile: policy and technical development in climate change and health). Each regional office should have a full-time project officer responsible for the integration of climate change into operational programmes; for this, four additional staff (full-time equivalent) will be required (skills profile: project management, environmental health).

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

Current biennium.

1. Resolution EB124.R6 Reducing health inequalities through action on the social determinants of health

2. Linkage to programme budget

Strategic objective:

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:

7.1 Significance of social and economic determinants of health recognized throughout the Organization and incorporated into normative work and technical collaboration with Member States and other partners.

7.2 Initiative taken by WHO in providing opportunities and means for intersectoral collaboration at national and international levels in order to address social and economic determinants of health and to encourage poverty reduction and sustainable development.

7.3 Social and economic data relevant to health collected, collated and analysed on a disaggregated basis (by sex, age, ethnicity, income, and health conditions, such as disease or disability).

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

Implementation of the resolution will greatly assist the ability of the Organization to integrate work on the social determinants of health into its programmes and to support Member States in developing national capacity to measure health inequities and implement intersectoral policies on the social determinants of health.

3. Financial implications

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

US\$ 29 850 000 over the years 2009, 2010 and 2011.

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

US\$ 9 760 000 covering work at headquarters level to extend existing activities, and work in regional offices to build capacity and facilitate regional efforts, in line with the resolution.

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

All activities for the biennium 2008–2009 can be subsumed under the Programme budget 2008–2009.

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

Not applicable.

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

All levels of the Organization.

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

3.5 staff members (full-time equivalent) across the six regional offices in order to build regional capacity to work with countries, in line with the resolution.

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

Three years (2009–2011), with a report on progress to be submitted to the Sixty-fifth World Health Assembly in 2012 in line with the resolution.

1. Resolution EB124.R7 Chagas disease: control and elimination**2. Linkage to programme budget**

Strategic objective:

Organization-wide expected result:

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

- 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 aims to strengthen activities linked with the following:

- the information and surveillance system on the epidemiological distribution of Chagas disease
- an enhanced and renewed strategy towards the elimination of Chagas disease.

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

A maximum of US\$ 2 million per year including:

- one staff member in the professional category for five years (at US\$ 188 000 per year)
- distribution of medicines for five years (at US\$ 300 000 per year)
- documentation costs, including guidelines and dissemination for five years (at US\$ 100 000 per year)
- technical support to regions and countries for five years (at US\$ 1.4 million per year).

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

- Distribution of medicines (US\$ 350 000)
- Documentation costs including guidelines and dissemination (US\$ 150 000)
- Technical support to regions and countries (US\$ 500 000)

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

This is a new initiative, the planned activities for which were not budgeted in the original workplan.

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

Through an agreement with a pharmaceutical company (expected to be finalized in due course).

4. 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 collaboration with regional and country offices.

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

No additional staff required beyond those planned for the biennium 2008–2009.

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

About 60 months.

1. Resolution EB124.R8 Primary health care, including health system strengthening

2. Linkage to programme budget

Strategic objective:

Organization-wide expected result:

Strategic objectives 1–11 (all technical objectives)

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

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

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

3. Financial implications

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

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

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

care), and (iii) stepping up support to and exchange between countries.

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

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

US\$ 1.8 million (see note above).

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

50%, or US\$ 900 000.

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

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

4. Administrative implications

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

All levels of the Organization will be involved.

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

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

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

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

1. Resolution EB124.R9 Traditional medicine

2. Linkage to programme budget

Strategic objective:

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

Organization-wide expected result:

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

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

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

In the WHO traditional medicine strategy, the indicators are the number of Member States with (i) a national policy on traditional medicine; (ii) regulations on herbal medicines; and (iii) national research institutions for traditional medicine.

3. Financial implications

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

The resolution requires sustained effort to be made in a wide range of activities. For practical budgetary purposes, however, costs of staff and activities to implement the resolution are estimated for the period 2009–2013 and amount to a total of US\$ 23 million (US\$ 5 million in 2008–2009, US\$ 8 million in 2010–2011 and US\$ 10 million in 2012–2013).

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

A total of US\$ 5 million in 2009. The breakdown of this figure is provided below.

Headquarters: US\$ 3 million (including activities and staffing).

In the regions, most of the regional offices lack a budget to support activities in the field of traditional medicine. Costs in the regional offices are as follows: Regional Office for Africa, US\$ 600 000; Regional Office for the Americas, US\$ 300 000; Regional Office for South-East Asia, US\$ 200 000; Regional Office for Europe, US\$ 300 000; Regional Office for the Eastern Mediterranean, US\$ 300 000; and Regional Office for the Western Pacific, US\$ 300 000.

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

US\$ 4 million can be absorbed under the Programme budget 2008–2009. Thus additional funding of US\$ 1 million is required for full implementation of the activities referred to in the draft resolution.

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

Member State's voluntary contributions; bilateral donors; private foundations; local governments within Member States; other United Nations agencies, programmes and foundations; nongovernmental organizations; professional associations; and WHO collaborating centres.

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

The work will be undertaken at headquarters, in all regional offices and in selected country offices.

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

At present, there is a serious lack of staff at all levels to undertake the activities required. Implementing the resolution over the five-year period will require additional staff in the professional category in a core team both at headquarters and regional offices, as well as staff in the general service category at headquarters.

At headquarters: three full-time staff in the professional category at US\$ 900 000 and two full-time staff in the general service category at US\$ 300 000 are required for each year of implementation.

In the regional offices: three full-time staff in the professional category at US\$ 900 000 and three full-time staff in the general service category at US\$ 500 000 are needed for each year of implementation.

In selected country offices: three full-time staff in the professional category are required at US\$ 600 000 per year.

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

Five years (2009–2013).

1. Resolution EB124.R10 Amendments to the Financial Regulations and Financial Rules**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:

13.2 Sound financial practices and efficient management of financial resources achieved through continuous monitoring and mobilization of resources to ensure the alignment of resources with the programme budgets.

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

Development and implementation of new International Public Sector Accounting Standards, including training and dissemination.

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

- US\$ 500 000 this biennium to adapt the Global Management System to the Financial Rules and Financial Regulations which have been made compliant with the International Public Sector Accounting Standards. Other costs relate to preparation of new policies and procedures and revision of the existing Finance Manual. Ongoing costs, mostly for training, may amount to some US\$ 200 000 per biennium.

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

- US\$ 500 000, incurred at headquarters, primarily for staff time. Regional offices may have some costs for becoming compliant with the amended Financial Rules and Financial Regulations.

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

- Existing resources will be used for planned activities.

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

- Additional costs for training, estimated at US\$ 200 000 per biennium, could come from WHO's training fund.

4. Administrative implications

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

- Adapting the Global Management System, and modifying existing policies, procedures and manuals will be undertaken at headquarters. Training in regions may be required.

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

- None.

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

- Preparation for the application of the amended Financial Rules and Financial Regulations will be completed by the end of 2009; training will be undertaken thereafter.

1. Resolution EB124.R11 Relations with nongovernmental organizations ¹	
2. Linkage to programme budget	
Strategic objective: <i>International Medical Corps</i>	Organization-wide expected result:
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.	5.2 Norms and standards developed, capacity built and technical support provided to Member States for a timely response to disasters associated with natural hazards and to conflict-related crises. 5.3 Norms and standards developed, capacity built and technical support provided to Member States for assessing needs and for planning and implementing interventions during the transition and recovery phases of conflicts and disasters. 5.6 Effective communications issued, partnerships formed and coordination developed with other organizations in the United Nations system, governments, local and international nongovernmental organizations, academic institutions and professional associations at the country, regional and global levels.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The Organization-wide expected results are linked as follows: under 5.2, activities in the area of emergency response and operations, namely, providing effective support in crisis management; under 5.3, work in the area of recovery and transition, namely, supporting the work of the Global Health Cluster; ² and under 5.6, work to strengthen interagency health partnerships.	
3. Financial implications	
(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)	
Nil.	
(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)	
Not applicable.	

¹ In accordance with the Principles governing relations between WHO and nongovernmental organizations (adopted by the Fortieth World Health Assembly in its resolution WHA40.25) and, inter alia, on the basis of a three-year plan for collaboration based on mutually agreed objectives, the Executive Board may decide, as appropriate, to admit a nongovernmental organization into official relations with WHO, and to maintain or discontinue existing relations. Document EB124/25 contains a draft resolution expressing such decisions. The general costs connected with the application of the Principles, including informing nongovernmental organizations that relations have been discontinued, are subsumed under strategic objective 12 of the Medium-term strategic plan 2008–2013.

However, the costs, if any, of the collaboration plans are incurred by the technical department with which the plans were agreed. Therefore, this report refers to the relevant strategic objective for each nongovernmental organization that will be admitted into official relations with WHO if the Executive Board adopts the resolution set out in document EB124/25. The plans for collaboration appear in the restricted document EB124/NGO/1.

² The Inter-Agency Standing Committee was established in June 1992 in response to United Nations General Assembly resolution 46/182 on the strengthening of the coordination of humanitarian emergency assistance in the United Nations. The Standing Committee was instrumental in organizing a cluster approach to improve the effectiveness of humanitarian response. WHO is the lead agency for the Health Cluster, which is one of 11 clusters working towards common objectives.

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

Not applicable.

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

Not applicable.

4. Administrative implications

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

At headquarters and in the regional offices, and in countries and areas affected by crises and disasters.

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

Not applicable.

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

Three years for implementation, after which the Executive Board will evaluate the relations, in accordance with resolution WHA40.25.

1. Resolution EB124.R12 WHO's role and responsibilities in health research

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:

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

10.6 National health research for development of health systems strengthened in the context of regional and international research and engagement of civil society.

In response to the request made by the Health Assembly in resolution WHA60.15, the strategy has a fundamental objective to improve the management and organization of WHO's research activities. As such, it is linked to all other strategic objectives except number 12, which facilitates the work of WHO to achieve all other strategic objectives.

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

The resolution is fully consistent with both the expected results and the five indicators associated with them. Implementation of the strategy is expected to contribute to meeting the targets articulated under the expected results. Baselines will remain largely the same.

3. Financial implications

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

US\$ 39 million will be required for the 10 year life-cycle of the resolution.

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

US\$ 3 million (US\$ 1.4 million for staff, US\$ 1.6 million for activities), mostly at headquarters but with activities extending to all regions, starting with the Regional Office for Africa and the Regional Office for the Americas, as regional research strategies/policies are already under development or consideration in these regions. Of the US\$ 1.6 million needed for activities, it is estimated that 60% will be spent in the regions and countries.

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

About US\$ 1.5 million of the proposed expenditure for the remainder of the current biennium can be absorbed under existing programmed activities. Additional funding of US\$ 1.5 million is therefore required.

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

Resources will be raised through a focused resource mobilization effort. Funds were secured for the development phase of the strategy (the Bill & Melinda Gates Foundation, the Wellcome Trust).

4. Administrative implications

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

The strategy will be implemented at all levels of the Organization. Importantly, regional offices will play a central role in implementing regional research strategies, which will be developed with the global strategy as a guiding framework, taking into consideration country needs through incorporation into country cooperation strategies. Headquarters will have to play this role in relation to headquarters-based research activities; it will also be responsible for setting standards, providing guidance, convening research funders and gathering information on regional implementation, and will support the implementation of certain activities in the regions and countries.

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

Four additional full-time equivalents will be required at headquarters (three in the professional category and one in the general service category). The skills needed relate to health research systems, information technology/database management and communications. Each regional office should be strengthened with one additional full-time equivalent (in the professional category) in order to help in the development of regional strategies and their implementation, and in intensifying collaboration with country offices to provide support to Member States in implementing the strategy.

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

The strategy will be implemented in a phased manner within a broad time frame of 10 years. The first two years of the strategy will focus on establishing governance and coordination mechanism(s) at headquarters based on activities identified, and pursuing consultations with regional offices. Implementation at headquarters will begin in 2009; in the regions it will begin in late 2009 or 2010, starting with the African Region and the Region of the Americas. Implementation in the remaining four regions will take place after 2010. Within this 10-year time frame, there are also plans to perform periodic monitoring and to report on progress on a biennial basis, and to organize a four-yearly high-level consultation in order to define global research priorities.

1. Resolution EB124.R13 Human organ and tissue transplantation

2. Linkage to programme budget

Strategic objective:	Organization-wide expected results:
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.	7.4 Ethics- and rights-based approaches to health promoted within WHO and at national and global levels.
11. To ensure improved access, quality and use of medical products and technologies.	11.1 Formulation and monitoring of comprehensive national policies on access, quality and use of essential medical products and technologies advocated and supported. 11.2 International norms, standards and guidelines for the quality, safety, efficacy and cost-effective use of medical products and technologies developed and their national and/or regional implementation advocated and supported.

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

In endorsing the updated WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation, the resolution recognizes human cells, tissues and organs as being medical products of an exceptional nature; it thus mandates regulatory oversight for the safety, efficacy and ethics of donation and transplantation and is consistent with the expected results. Existing indicators are already reflecting this work in part and will be complemented by additional indicators on specific national regulatory authorities and vigilance on and surveillance, if needed.

3. Financial implications

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

US\$ 4.8 million are needed for the next four years. Of this amount, one half (US\$ 2.6 million) is needed at headquarters for global planning, normative and policy guidance and coordination between stakeholders; the remaining US\$ 2.2 million are needed for support activities at regional and country levels.

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

Total costs are estimated at US\$ 1 950 000, of which US\$ 300 000 will be incurred in the regions.

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

In addition to existing resources, US\$ 220 000 will be necessary to initiate a global network of health authorities involved in vigilance on and surveillance of ethical and safety risks in cell, tissue and organ donation and transplantation.

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

Additional funding from voluntary contributions is expected through active resource mobilization.

4. Administrative implications

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

All levels of the Organization will be involved.

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

At headquarters, the equivalent of one full-time staff member in the professional category will be required for the last six months of 2009 and the next two bienniums to establish and sustain a global collaborative network of national regulatory authorities in charge of the oversight of cell, tissue and organ transplantation.

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

In 2013 a progress report will be submitted to the Sixty-sixth World Health Assembly.

1. Resolution EB124.R14 Confirmation of amendments to Staff Rules

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:

13.3 Human resource policies and practices in place to attract and retain top talent, promote learning and professional development, manage performance and foster ethical behaviour.

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

The amendments represent the implementation of recommendations contained in the report of the International Civil Service Commission, which has been submitted to the United Nations General Assembly for consideration at its sixty-third session. These amendments aim to ensure that WHO's compensation system complies with the decisions that are expected to be taken by the General Assembly.

3. Financial implications

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

Total estimated annual cost US\$ 1 413 457, made up of revision to the education grant, US\$ 213 750; operation of the new mobility and hardship scheme, US\$ 434 707; children and secondary dependent's allowance levels, US\$ 675 000; and hazard pay, US\$ 90 000.

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

As implementation takes place as of 1 January 2009, the costs apply for the biennium 2008–2009.

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

All the costs can be subsumed.

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

Not applicable.

4. Administrative implications

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

All levels of the Organization will be involved.

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

The amendments do not require additional staffing.

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

Implementation will take place from 1 January 2009.