



WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD

128TH SESSION

GENEVA, 17–24 January 2011

**RESOLUTIONS AND DECISIONS
ANNEXES**

GENEVA
2011

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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

The designations used 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 128th session of the Executive Board was held at WHO headquarters, Geneva, from 17 to 24 January 2011. 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 EB128/2011/REC/2.

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RESOLUTIONS

EB128.R1 WHO's role in the follow-up to the United Nations High-level Plenary Meeting of the General Assembly on the Millennium Development Goals (New York, September 2010)

Having considered the report on health-related Millennium Development Goals,¹

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

The Sixty-fourth World Health Assembly,

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

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

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

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

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

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

¹ Document EB128/7.

² See Annex 4 for the financial and administrative implications for the Secretariat of the adoption of this resolution.

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

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

Noting that the objectives of the Commission on Information and Accountability for Women's and Children's Health are:

- (1) to determine international institutional arrangements for global reporting, oversight and accountability on women's and children's health – this accountability framework will encompass results and resources, and identify the roles of the different partners involved;
- (2) to identify ways to improve monitoring of progress towards women's and children's health while minimizing the reporting burden on countries, including establishing a set of core indicators, efficient investment in data generation and better data sharing;
- (3) to propose actions to overcome major challenges to accountability at the country level, including strengthening of country capacity and addressing major data gaps such as the monitoring of vital events;
- (4) to identify opportunities for innovation provided by information technology that will facilitate improved accountability for results and resources, and to propose ways of ensuring that these opportunities are harnessed to bring maximum benefits to countries;

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

Stressing furthermore that the Commission on Information and Accountability for Women's and Children's Health should take into account relevant existing data collections and existing performance indicators,

REQUESTS the Director-General:

- (1) to ensure the effective engagement of all key stakeholders in the work of the Commission on Information and Accountability for Women's and Children's Health;
- (2) to report to the Sixty-fourth World Health Assembly on progress in the work of the Commission on Information and Accountability for Women's and Children's Health in connection with the agenda item concerning the Millennium Development Goals.

(Fifth meeting, 19 January 2011)

EB128.R2 Scale of assessments for 2012–2013

The Executive Board,

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

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

The Sixty-fourth World Health Assembly,

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

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

| Members and Associate Members | WHO scale for 2012–2013 % |
|--|--|
| Afghanistan | 0.0040 |
| Albania | 0.0100 |
| Algeria | 0.1280 |
| Andorra | 0.0070 |
| Angola | 0.0100 |
| Antigua and Barbuda | 0.0020 |
| Argentina | 0.2870 |
| Armenia | 0.0050 |
| Australia | 1.9331 |
| Austria | 0.8511 |
| Azerbaijan | 0.0150 |
| Bahamas | 0.0180 |
| Bahrain | 0.0390 |
| Bangladesh | 0.0100 |
| Barbados | 0.0080 |
| Belarus | 0.0420 |
| Belgium | 1.0751 |
| Belize | 0.0010 |
| Benin | 0.0030 |
| Bhutan | 0.0010 |
| Bolivia (Plurinational State of) | 0.0070 |
| Bosnia and Herzegovina | 0.0140 |
| Botswana | 0.0180 |
| Brazil | 1.6111 |
| Brunei Darussalam | 0.0280 |
| Bulgaria | 0.0380 |
| Burkina Faso | 0.0030 |
| Burundi | 0.0010 |

¹ Document EB128/25.

| Members and Associate Members | WHO scale for 2012–2013 % |
|--|--|
| Cambodia | 0.0030 |
| Cameroon | 0.0110 |
| Canada | 3.2072 |
| Cape Verde | 0.0010 |
| Central African Republic | 0.0010 |
| Chad | 0.0020 |
| Chile | 0.2360 |
| China | 3.1892 |
| Colombia | 0.1440 |
| Comoros | 0.0010 |
| Congo | 0.0030 |
| Cook Islands | 0.0010 |
| Costa Rica | 0.0340 |
| Côte d'Ivoire | 0.0100 |
| Croatia | 0.0970 |
| Cuba | 0.0710 |
| Cyprus | 0.0460 |
| Czech Republic | 0.3490 |
| Democratic People's Republic of Korea | 0.0070 |
| Democratic Republic of the Congo | 0.0030 |
| Denmark | 0.7361 |
| Djibouti | 0.0010 |
| Dominica | 0.0010 |
| Dominican Republic | 0.0420 |
| Ecuador | 0.0400 |
| Egypt | 0.0940 |
| El Salvador | 0.0190 |
| Equatorial Guinea | 0.0080 |
| Eritrea | 0.0010 |
| Estonia | 0.0400 |
| Ethiopia | 0.0080 |
| Fiji | 0.0040 |
| Finland | 0.5660 |
| France | 6.1234 |
| Gabon | 0.0140 |
| Gambia | 0.0010 |
| Georgia | 0.0060 |
| Germany | 8.0186 |
| Ghana | 0.0060 |
| Greece | 0.6910 |
| Grenada | 0.0010 |
| Guatemala | 0.0280 |
| Guinea | 0.0020 |
| Guinea-Bissau | 0.0010 |
| Guyana | 0.0010 |
| Haiti | 0.0030 |
| Honduras | 0.0080 |
| Hungary | 0.2910 |

| Members and Associate Members | WHO scale for 2012–2013 % |
|--|--|
| Iceland | 0.0420 |
| India | 0.5340 |
| Indonesia | 0.2380 |
| Iran (Islamic Republic of) | 0.2330 |
| Iraq | 0.0200 |
| Ireland | 0.4980 |
| Israel | 0.3840 |
| Italy | 4.9994 |
| Jamaica | 0.0140 |
| Japan | 12.5309 |
| Jordan | 0.0140 |
| Kazakhstan | 0.0760 |
| Kenya | 0.0120 |
| Kiribati | 0.0010 |
| Kuwait | 0.2630 |
| Kyrgyzstan | 0.0010 |
| Lao People's Democratic Republic | 0.0010 |
| Latvia | 0.0380 |
| Lebanon | 0.0330 |
| Lesotho | 0.0010 |
| Liberia | 0.0010 |
| Libyan Arab Jamahiriya | 0.1290 |
| Lithuania | 0.0650 |
| Luxembourg | 0.0900 |
| Madagascar | 0.0030 |
| Malawi | 0.0010 |
| Malaysia | 0.2530 |
| Maldives | 0.0010 |
| Mali | 0.0030 |
| Malta | 0.0170 |
| Marshall Islands | 0.0010 |
| Mauritania | 0.0010 |
| Mauritius | 0.0110 |
| Mexico | 2.3562 |
| Micronesia (Federated States of) | 0.0010 |
| Monaco | 0.0030 |
| Mongolia | 0.0020 |
| Montenegro | 0.0040 |
| Morocco | 0.0580 |
| Mozambique | 0.0030 |
| Myanmar | 0.0060 |
| Namibia | 0.0080 |
| Nauru | 0.0010 |
| Nepal | 0.0060 |
| Netherlands | 1.8551 |
| New Zealand | 0.2730 |
| Nicaragua | 0.0030 |
| Niger | 0.0020 |
| Nigeria | 0.0780 |

| Members and Associate Members | WHO scale for 2012–2013 % |
|--|--|
| Niue | 0.0010 |
| Norway | 0.8711 |
| Oman | 0.0860 |
| Pakistan | 0.0820 |
| Palau | 0.0010 |
| Panama | 0.0220 |
| Papua New Guinea | 0.0020 |
| Paraguay | 0.0070 |
| Peru | 0.0900 |
| Philippines | 0.0900 |
| Poland | 0.8281 |
| Portugal | 0.5110 |
| Puerto Rico | 0.0010 |
| Qatar | 0.1350 |
| Republic of Korea | 2.2602 |
| Republic of Moldova | 0.0020 |
| Romania | 0.1770 |
| Russian Federation | 1.6021 |
| Rwanda | 0.0010 |
| Saint Kitts and Nevis | 0.0010 |
| Saint Lucia | 0.0010 |
| Saint Vincent and the Grenadines | 0.0010 |
| Samoa | 0.0010 |
| San Marino | 0.0030 |
| Sao Tome and Principe | 0.0010 |
| Saudi Arabia | 0.8301 |
| Senegal | 0.0060 |
| Serbia | 0.0370 |
| Seychelles | 0.0020 |
| Sierra Leone | 0.0010 |
| Singapore | 0.3350 |
| Slovakia | 0.1420 |
| Slovenia | 0.1030 |
| Solomon Islands | 0.0010 |
| Somalia | 0.0010 |
| South Africa | 0.3850 |
| Spain | 3.1772 |
| Sri Lanka | 0.0190 |
| Sudan | 0.0100 |
| Suriname | 0.0030 |
| Swaziland | 0.0030 |
| Sweden | 1.0641 |
| Switzerland | 1.1301 |
| Syrian Arab Republic | 0.0250 |
| Tajikistan | 0.0020 |
| Thailand | 0.2090 |
| The former Yugoslav Republic of Macedonia | 0.0070 |
| Timor-Leste | 0.0010 |

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

(Seventh meeting, 20 January 2011)

EB128.R3 Amendments to the Financial Regulations¹

The Executive Board,

Having considered the report on amendments to the Financial Regulations and Financial Rules, relating in particular to annual financial audits and the full adoption 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,

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

¹ See Annex 1.

² Document EB128/26.

³ See Annex 4 for the financial and administrative implications for the Secretariat of the adoption of this resolution.

The Sixty-fourth World Health Assembly,

Having considered the report on amendments to the Financial Regulations;

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

ADOPTS the amendments to Financial Regulations 14.1, 14.8 and 14.9 to be effective as from 1 January 2012.

(Eighth meeting, 20 January 2011)

EB128.R4 Confirmation of amendments to the Staff Rules¹

The Executive Board,

1. 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 February 2011 concerning post classification, medical certification and inoculations, promotion, reassignment, annual leave, leave without pay, sick leave, sick leave under insurance cover, and abolition of post, and with effect from 1 January 2011 concerning the remuneration of staff in the professional and higher categories, and with effect from the school year in progress on 1 January 2011 for education grant;
2. REQUESTS the Director-General to submit for consideration at the 129th session of the Executive Board revisions to Staff Rule 420.2 which would make more rigorous the criteria for granting continuing appointments and to include in the submission a proposed envelope for continuing appointments based on WHO's core staffing needs.

(Eighth meeting, 20 January 2011)

EB128.R5 Salaries of staff in ungraded posts and of the Director-General

The Executive Board,

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

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

The Sixty-fourth 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 See Annex 2, and Annex 4 for the financial and administrative implications for the Secretariat of the adoption of this resolution.

² Document EB128/36.

1. ESTABLISHES the salaries of Assistant Directors-General and Regional Directors at US\$ 185 809 gross per annum before staff assessment, resulting in a modified net salary of US\$ 133 776 (dependency rate) or US\$ 121 140 (single rate);
2. ESTABLISHES the salary of the Deputy Director-General at US\$ 204 391 gross per annum before staff assessment, resulting in a modified net salary of US\$ 145 854 (dependency rate) or US\$ 131 261 (single rate);
3. ESTABLISHES the salary of the Director-General at US\$ 251 188 gross per annum before staff assessment, resulting in a modified net salary of US\$ 176 272 (dependency rate) or US\$ 156 760 (single rate);
4. DECIDES that those adjustments in remuneration shall take effect on 1 January 2011.

(Eighth meeting, 20 January 2011)

EB128.R6 Eradication of dracunculiasis

The Executive Board,

Having considered the report on dracunculiasis;¹

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

The Sixty-fourth World Health Assembly,

Having considered the report on dracunculiasis,

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

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

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

Noting with satisfaction the excellent results achieved by the countries where dracunculiasis is endemic in decreasing the number of cases from an estimated 3.5 million in 1986 to less than 3200 reported cases in 2009 and 1435 reported cases⁴ in 2010 (up to August);

¹ Document EB128/15.

² See Annex 4 for the financial and administrative implications for the Secretariat of adoption of the resolution.

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

⁴ Provisional figures.

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

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

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

(Eighth meeting, 20 January 2011)

EB128.R7 Cholera: mechanism for control and prevention

The Executive Board,

Having considered the report on cholera: mechanism for control and prevention,¹

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

The Sixty-fourth World Health Assembly,

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

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

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

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

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

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

Affirming that progress in achieving the health-related Millennium Development Goals, and particularly access to safe drinking-water and sanitation under Goal 7 (Ensure environmental sustainability), would decrease the occurrence and spread of cholera, and that

¹ Document EB128/13.

² See Annex 4 for the financial and administrative implications for the Secretariat of adoption of this resolution.

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

improving prevention and control of cholera will have a positive effect on other diarrhoeal diseases;

Recognizing that control of cholera is now entering a new phase with the development of safe, effective and potentially affordable oral cholera vaccines, and that this approach is complementary to, and should not substitute for, the existing effective prevention and control measures,

1. URGES all Member States:¹

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

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

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

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

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

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

¹ And, where applicable, regional economic integration organizations.

2. REQUESTS the Director-General:
- (1) to strengthen and enhance measures to ensure that the Organization continues to respond expeditiously and effectively to the needs of the countries affected by or at risk of outbreaks of cholera;
 - (2) to revitalize the Global Task Force on Cholera Control and to strengthen WHO's work in this area, including improved collaboration and coordination among relevant WHO departments and other relevant stakeholders;
 - (3) to strengthen the coordination of international assistance during cholera epidemics in terms of equipment, human and financial resources in order to ensure an effective and quick response;
 - (4) to provide technical support to countries for building their capacity to undertake effective control and prevention measures, including surveillance, early warning and response, laboratory capacity, risk assessment, case management, data collection and monitoring, and effective vaccine deployment;
 - (5) to further promote research, and encourage surveillance, on the emergence of altered variants and drug-resistant strains of *Vibrio cholerae*;
 - (6) to promote ongoing interventions to change behaviour and food and water safety measures, including training and advocacy programmes, in order to improve sanitary and hygienic practices as critical components of cholera prevention and control;
 - (7) to continue to support further research on safe, efficacious and affordable cholera vaccines, and to promote transfer of relevant vaccine manufacturing technologies to countries affected by or at risk of cholera in order to build capacity for local production of cholera vaccines;
 - (8) to develop updated and practical evidence-based policy guidelines, including on the feasibility and assessment of the appropriate and cost-effective use of oral cholera vaccines in low-income countries and on the definition of target groups;
 - (9) to liaise with relevant international funding agencies on possible support for introducing effective cholera vaccines in low-income countries;
 - (10) to report to the Sixty-fifth World Health Assembly, through the Executive Board, on the global cholera situation and efforts made in cholera prevention and control.

(Ninth meeting, 21 January 2011)

EB128.R8 Sustainable health financing structures and universal coverage

The Executive Board,

Having considered the reports on health system strengthening,¹

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

The Sixty-fourth World Health Assembly,

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

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

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

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

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

Having considered *The world health report 2008*⁴ and resolution WHA62.12, that highlighted universal coverage as one of the four key pillars of primary health care and services through patient-centred care, inclusive leadership and health in all policies;

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

¹ Documents EB128/8 and EB128/37.

² See Annex 4 for the financial and administrative implications for the Secretariat of adoption of this resolution.

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

⁴ *The world health report 2008. Primary health care: now more than ever*. Geneva, World Health Organization, 2008.

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

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

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

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

1. URGES Member States:¹

- (1) to ensure that health-financing systems evolve so as to avoid significant direct payments at the point of delivery and include a method for prepayment of financial contributions for health care and services as well as a mechanism to pool risks among the population in order to avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking the care needed;
- (2) to aim for affordable universal coverage and access for all citizens on the basis of equity and solidarity, so as to provide an adequate scope of health care and services and level of costs covered, as well as comprehensive and affordable preventive services through strengthening of equitable and sustainable financial resource budgeting;
- (3) to continue, as appropriate, to invest in and strengthen the health-delivery systems, in particular primary health care and services, and adequate human resources for health and health information systems, in order to ensure that all citizens have equitable access to health care and services;
- (4) to ensure that external funds for specific health interventions do not distort the attention given to health priorities in the country, that they increasingly comply with the principles of aid effectiveness, and that they contribute in a predictable way to the sustainability of financing;
- (5) to plan the transition of their health systems to universal coverage, while continuing to safeguard the quality of services and to meet the needs of the population in order to reduce poverty and to attain internationally agreed development goals, including the Millennium Development Goals;
- (6) to recognize that, when managing the transition of the health system to universal coverage, each option will need to be developed within the particular epidemiological, macroeconomic, sociocultural and political context of each country;

¹ And, where applicable, regional economic integration organizations.

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

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

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

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

(11) to establish and strengthen institutional capacity in order to generate country-level evidence and effective, evidence-based policy decision-making on the design of universal health coverage systems;

2. REQUESTS the Director-General:

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

(2) to work closely with other United Nations organizations, international development partners, foundations, academia and civil society organizations, in fostering efforts towards achieving universal coverage;

(3) to prepare a plan of action for WHO to support Member States in realizing universal coverage as envisaged by resolution WHA62.12 and *The world health report 2010*;¹

(4) to prepare an estimate of the number of people covered by a basic health insurance that provides access to basic health care and services, that estimate being broken down by country and WHO region;

(5) to provide, in response to requests from Member States, technical support for strengthening capacities and expertise in the development of health-financing systems, particularly equitable prepayment schemes, with a view to achieving universal coverage by providing comprehensive health care and services for all;

(6) to facilitate within existing forums the continuous sharing of experiences and lessons learnt on social health protection and universal coverage;

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

(7) to report to the Sixty-fifth World Health Assembly and thereafter every three years, through the Executive Board, on the implementation of this resolution, including on outstanding issues raised by Member States during the Sixty-fourth World Health Assembly.

(Tenth meeting, 21 January 2011)

EB128.R9 Health workforce strengthening

The Executive Board,

Having considered the reports on health system strengthening,¹

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

The Sixty-fourth World Health Assembly,

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

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

Taking note of the WHO Global Code of Practice on the International Recruitment of Health Personnel,³ which, *inter alia*, recognized that an adequate and accessible health workforce is fundamental to an integrated and effective health system and for the provision of health services, and that Member States should take measures to meet their own health personnel needs, *i.e.* take measures to educate, retain and sustain a health workforce that is appropriate for the specific conditions of each country;

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

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

¹ Documents EB128/8 and EB128/37.

² See Annex 4 for the financial and administrative implications for the Secretariat of adoption of this resolution.

³ Adopted in resolution WHA63.16.

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

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

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

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

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

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

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

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

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

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

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

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

1. URGES Member States:¹

- (1) to implement the voluntary WHO Global Code of Practice on the International Recruitment of Health Personnel in order that both source and destination countries may derive benefits from the international migration of health personnel and in order to mitigate the negative effects of health worker migration on health systems, particularly in countries with critical health worker shortages;
- (2) to prioritize, in the context of global economic conditions, public sector spending on health, as appropriate, to ensure that sufficient financial resources are available for the implementation of policies and strategies to scale-up and retain the health workforce, particularly in developing countries, and to recognize it as an investment in the health of the population that contributes to social and economic development;
- (3) to consider developing or maintaining a national health workforce plan as an integral part of a validated national health plan, in accordance with national and subnational responsibilities with increased efforts towards effective implementation and monitoring, as appropriate in the national context;
- (4) to use and implement evidence-based findings and strategies, including those from the Global Health Workforce Alliance Taskforce on Scaling Up Education and Training, for the successful scaling-up of health worker education and training;
- (5) to participate actively in the ongoing work on the WHO policy guidelines on transformative scale-up of health professional education in order to increase the workforce numbers and relevant skill-mix in response to country health needs and health systems context;
- (6) to develop strategies and policies to increase the availability of motivated and skilled health workers in remote and rural areas, with reference to WHO global policy recommendations on increasing access to health workers in remote and rural areas through improved retention of the health workforce;
- (7) to implement the relevant recommendations for increased retention of health workers in rural areas, including: improved living conditions; safe and supportive working environment; outreach support; career development and advancement programmes; supporting professional networks; and social recognition of dedicated health personnel;
- (8) to develop or strengthen in-country capacity for health workforce information systems in order to guide, accelerate and improve country action including the collection, processing and disseminating of information on their health workforce, covering, but not limited to, stock, education and training capacity, distribution, migration and expenditures;;
- (9) to work with other sectors to generate evidence and introduce effective policy interventions in order to address other factors that affect the availability of health workers

¹ And, where applicable, regional economic integration organizations.

in rural or remote areas, such as socioeconomic deprivation, geographical barriers and distance, transport and the acceptability of services;

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

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

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

3. REQUESTS the Director-General:

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

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

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

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

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

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

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

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

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

(Tenth meeting, 21 January 2011)

EB128.R10 Strengthening national health emergency and disaster management capacities and resilience of health systems

The Executive Board

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

The Sixty-fourth World Health Assembly,

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

Recalling United Nations' General Assembly resolution 60/195, which endorsed the Hyogo Declaration and the Hyogo Framework for Action 2005–2015: Building the Resilience of Nations and Communities to Disasters, as well as resolutions 61/198, 62/192, 63/216, 64/200 and 64/251, which, inter alia, called upon Member States to increase efforts to implement the Hyogo Framework, to strengthen risk-reduction and emergency preparedness measures at all levels, and to encourage the international community and relevant United Nations' entities to support national efforts aimed at strengthening capacity to prepare for and respond to disasters;

Reaffirming that countries have responsibility for ensuring the protection of the health, safety and welfare of their people and for ensuring the resilience and self-reliance of the health

¹ See Annex 4 for the financial and administrative implications for the Secretariat of adoption of this resolution.

system, which is critical for minimizing health hazards and vulnerabilities and delivering effective response and recovery in emergencies and disasters;

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

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

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

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

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

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

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

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

Building on the International Strategy for Disaster Reduction, the 2008–2009 World Disaster Reduction Campaign on Hospitals Safe from Disasters, the 2010–2011 Campaign on Disaster Resilient Cities, World Health Day 2008 on Climate Change and Health, World Health Day 2009 on Hospitals Safe in Emergencies, and World Health Day 2010 on Urban Health Matters, which have resulted in local, subnational, national and global actions on reducing risks to health from emergencies and disasters;

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

1. URGES Member States:¹

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

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

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

(4) to promote regional and subregional collaboration, including sharing of experience and expertise for capacity development, in risk-reduction, response and recovery;

(5) to strengthen the role of the local health workforce in the health emergency management system in order to provide local leadership and health services, through enhanced planning, training, and access to other resources;

2. REQUESTS the Director-General:

(1) to ensure that WHO at all levels has enhanced capacity and resources, and optimizes its expertise across all disciplines in the Organization, in order to provide the necessary technical guidance and support to Member States and partners for developing health emergency and disaster risk-management programmes at national, subnational and local levels;

(2) to strengthen collaboration with and ensure coherence and complementarity of actions with those of relevant entities, including those in the public, private, nongovernmental and academic sectors, in order to support country and community health emergency and disaster risk- management, which includes disaster risk-reduction,

¹ And, where applicable, regional economic integration organizations.

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

as well as ongoing efforts by Member States to implement the International Health Regulations (2005);

(3) to strengthen the evidence base for health emergency and disaster risk-management including operational research and economic assessments;

(4) to support national and subnational assessments of risks and capacities for health emergency and disaster risk-management, as a basis for catalysing action and strengthening national and subnational health emergency and disaster risk-management capacities, including disaster risk-reduction;

(5) to report to the Sixty-sixth World Health Assembly through the Executive Board at its 132nd session, on progress made in implementing this resolution;

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

(Tenth meeting, 21 January 2011)

EB128.R11 Strengthening nursing and midwifery

The Executive Board,

Having considered the reports on health system strengthening,¹

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

The Sixty-fourth World Health Assembly,

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

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

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

Acknowledging resolution WHA62.12 on primary health care, including health system strengthening, which called, inter alia, for the renewal and strengthening of primary health care,

¹ Documents EB128/8 and EB128/37.

² See Annex 4 for the financial and administrative implications for the Secretariat of adoption of this resolution.

as well as urging Member States to train and retain adequate numbers of health workers, with appropriate skill mix, including primary care nurses and midwives, in order to redress current shortages of health workers to respond effectively to people's health needs;

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

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

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

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

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

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

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

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

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

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

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

² Adopted in resolution WHA63.16.

³ See documents A61/17 and A63/27.

⁴ Document WHO/HRH/HPN/10.1.

1. URGES Member States to demonstrate their commitment to strengthening nursing and midwifery by:

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

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

2. REQUESTS the Director-General:

- (1) to strengthen WHO's capacity for development and implementation of effective nursing and midwifery policies and programmes through continued investment and appointment of professional nurses and midwives to specialist posts in the Secretariat both at headquarters and in regions;
- (2) to engage actively the knowledge and expertise of the Global Advisory Group on Nursing and Midwifery in key policies and programmes that pertain to health systems, the social determinants of health, human resources for health and the Millennium Development Goals;
- (3) to provide technical support and evidence for the development and implementation of policies, strategies and programmes on interprofessional education and collaborative practice, and on community health nursing services;
- (4) to provide support to Member States in optimizing the contributions of nursing and midwifery to implementing national health policies and achieving the internationally agreed health-related development goals, including those contained in the Millennium Declaration;
- (5) to encourage the involvement of nurses and midwives in the integrated planning of human resources for health, particularly with respect to strategies for maintaining adequate numbers of competent nurses and midwives;
- (6) to report on progress in implementing this resolution to the Sixty-fifth and Sixty-seventh World Health Assembly, through the Executive Board.

(Tenth meeting, 21 January 2011)

EB128.R12 Strengthening national policy dialogue to build more robust health policies, strategies and plans

The Executive Board,

Having considered the report on health system strengthening: improving support to policy dialogue around national health policies, strategies and plans,¹

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

The Sixty-fourth World Health Assembly,

Having considered the importance of policy directions suggested by the world health reports for 2008 and 2010;¹ resolution WHA62.12 on primary health care, including health

¹ Document EB128/8.

² See Annex 4 for the financial and administrative implications for the Secretariat of adoption of this resolution.

system strengthening; resolutions EUR/RC60/R5 on addressing key public health and health policy challenges in Europe: moving forwards in the quest for better health in the WHO European Region; WPR/RC61.R2 on the Western Pacific Regional Strategy for health systems based on the values of primary health care; AFR/RC60/R1 on a strategy for addressing key determinants of health in the African Region and documents AFR/RC60/7 on health systems strengthening: improving district health service delivery, and community ownership and participation and SEA/RC63/9 on the development of national health plans and strategies;

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

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

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

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

1. URGES Member States:

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

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

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

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

(5) to regularly monitor, review and adjust their national or subnational health policies, strategies and plans with a view to adjusting them to respond to evolving challenges and opportunities, and to involve all relevant stakeholders;

¹ *The world health report 2008. Primary health care (now more than ever)*. Geneva, World Health Organization, 2008. *The world health report 2010. Health systems financing: the path to universal coverage*. Geneva, World Health Organization, 2010.

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

(Tenth meeting, 21 January 2011)

EB128.R13 Malaria

The Executive Board,

Having considered the report on malaria,¹

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

The Sixty-fourth World Health Assembly,

Having considered the report on malaria;

¹ Document EB128/14.

² See Annex 4 for the financial and administrative implications for the Secretariat of adoption of this resolution.

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

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

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

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

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

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

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

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

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

Recognizing the resolution adopted at the 18th Roll Back Malaria Board Meeting on ACT Manufacturing in malaria-endemic countries,¹

1. URGES Member States:

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

¹ Resolution RBM/BOM/2010/RES.129.

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- (2) to undertake comprehensive reviews of malaria programmes as an essential step in developing strategic and operational plans for achieving and maintaining universal access to and coverage of malaria interventions, notably:
- (a) recommended vector-control operations for all people at risk, and maintenance of effective coverage through well designed and executed strategies for the replacement of long-lasting insecticide-treated bednets, and targeted communication about their usage;
 - (b) prompt diagnostic testing of all suspected cases of malaria and effective treatment with artemisinin-based combination therapy of patients with confirmed falciparum malaria in both the public and private sectors at all levels of the health system, including the community level, and to use the expansion of diagnostic services as an opportunity to strengthen malaria surveillance;
- (3) in order to sustain the advances in malaria control, to take immediate action to combat the major threats, namely:
- (a) resistance to artemisinin-based medicines, by strengthening regulatory services in the public and private sectors, working to halt the use of oral artemisinin-based monotherapies and substandard medicines not meeting WHO prequalification standards or strict national regulatory authority standards, introducing quality-assurance mechanisms, and improving supply-chain management for all malaria commodities and services;
 - (b) resistance to insecticides, by adopting best practices such as rotation of insecticides used for indoor residual spraying and using insecticides approved for indoor residual spraying from insecticide classes other than pyrethroids and compounds sharing cross-resistance with pyrethroids when technically appropriate alternatives are available in areas where usage of insecticide-treated bednets is high;
- (4) to use the expansion of interventions for malaria prevention and control as an entry point for strengthening health systems, including laboratory services, maternal and child health services at peripheral health facilities, integrated management of illnesses at the community level, and timely and accurate surveillance;
- (5) to maintain core national competencies for malaria control by sustaining a strong cadre of malaria experts, including entomologists, at all levels of the health-care system, where appropriate;
- (6) to comply with existing commitments and international regulations on the use of pesticides, in particular the Stockholm Convention on Persistent Organic Pollutants (Stockholm, 2004);
- (7) to increase funding for research and development in malaria prevention, control and treatment;

2. CALLS upon the international partners, including international organizations, financing bodies, research institutions, civil society, and the private sector:

(1) to ensure adequate and predictable global funding so that the global malaria targets for 2015 can be met and malaria-control efforts can be sustained in order to contribute to attaining the health-related Millennium Development Goals;

(2) to harmonize the provision of support to countries for implementing WHO-recommended policies and strategies based on local endemicity of malaria, using commodities that meet WHO prequalification standards or strict national regulatory authority standards, in order to secure universal access with vector-control and other prevention measures, diagnostic testing of suspected cases of malaria, and rational treatment of patients with confirmed malaria, as well as timely malaria surveillance systems;

(3) to support initiatives for the discovery and development of new medicines and insecticides to replace those whose usefulness is being lost through resistance, and to support both basic research on innovative tools for control and elimination of malaria (including vaccines) and operational research to overcome constraints limiting the expansion and practical effectiveness of existing interventions;

(4) to collaborate with WHO in order to support countries in accomplishing malaria goals and to progress to elimination;

(5) to focus on particularly vulnerable populations in high-burden countries, such as tribal people threatened by forest malaria and people in fragile situations;

(6) to work together to support infrastructure development and the training of the pharmaceutical manufacturers from countries endemic for malaria in order to increase access to cost-competitive artemisinin-based combination therapies that meet international quality standards;

3. REQUESTS the Director-General:

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

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

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

(4) to provide support to Member States in identifying new opportunities for malaria control, as well as combating major threats, notably plasmodial resistance to antimalarial

agents and mosquito resistance to insecticides, through the development and implementation of the Global Plan for Artemisinin Resistance Containment and a global plan for the prevention and management of insecticide resistance;

(5) to promote transfer of technology to manufacturers of artemisinin-based combination therapies in malaria-endemic countries in order to strengthen their capacity to meet WHO prequalification standards;

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

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

(Eleventh meeting, 22 January 2011)

EB128.R14 Election of the Director-General of the World Health Organization

The Executive Board,

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

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

Reaffirming the continued relevance of the criteria that should be met by the candidate for the post of Director-General, as adopted by the Executive Board in resolution EB97.R10;

Recognizing the importance of further strengthening transparency, fairness and equity among Member States of the six regions of the World Health Organization in the process and method of nomination and appointment of the Director-General of the Organization;

Acknowledging that the successful candidate for the post of the Director-General can come from any region but that candidates appointed to this post have so far only come from three out of the six regions of the Organization;

Recognizing that due regard should be paid to the importance of recruiting future Directors-General on as wide a geographical basis as possible from Member States of the six regions of the Organization;

Having considered the report on election of the Director-General of the World Health Organization,¹ and taking into account an earlier report on the Director-General of the World Health Organization,²

¹ Document EB128/27.

² Document EB122/17.

1. DECIDES to establish a time-bound and results-oriented working group on the process and methods of the election of the Director-General of the World Health Organization, open to all Member States;¹
2. REQUESTS the Director-General to convene the working group on the process and methods of the election of the Director-General of the World Health Organization as soon as possible and to facilitate its work;
3. DECIDES that the working group on the process and methods of the election of the Director-General of the World Health Organization will examine the following matters with a view to enhancing fairness, transparency and equity among the Member States of the six regions of the World Health Organization with respect to the process of nomination and appointment of the Director-General of the World Health Organization:
 - (1) review and analyse all the aspects of the nomination and appointment process of the Director-General;
 - (2) identify, in light of current concerns of a significant number of Member States relating to the nomination and appointment process and methods, the rules, procedures and/or steps that could be either revised, enhanced and/or added to improve the transparency, fairness and equity of the election of the Director-General with a view, inter alia, to ensuring that the recruitment of this Official be in harmony with the provisions of Article 101, paragraph 3 of the Charter of the United Nations;
 - (3) make specific recommendations on the above;
4. FURTHER DECIDES that the working group on the process and methods of the election of the Director-General of the World Health Organization, in undertaking its work, will take into account all relevant WHO and United Nations documentation and resolutions;
5. FURTHER DECIDES that the working group on the process and methods of the election of the Director-General of the World Health Organization shall submit an interim progress report to the Sixty-fourth World Health Assembly and a final report, including its recommendations in relation to issues set out in paragraph 3 above, to the Executive Board at its 130th session for final recommendations by the latter to the Sixty-fifth World Health Assembly.

(Twelfth meeting, 24 January 2011)

EB128.R15 Child injury prevention

The Executive Board,

Having considered the report on child injury prevention,²

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

¹ And, where applicable, regional economic integration organizations.

² Document EB128/19.

The Sixty-fourth World Health Assembly,

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

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

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

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

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

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

Welcoming the joint WHO/UNICEF *World report on child injury prevention*² and its recommendations for public health policy and programming;

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

¹ See Annex 4 for the financial and administrative implications for the Secretariat of adoption of this resolution.

² *World report on child injury prevention*, Geneva, World Health Organization, and New York, United Nations Children's Fund, 2008.

1. URGES Member States:

(1) to prioritize the prevention of child injury among child issues and ensure that intersectoral coordination mechanisms necessary to prevent child injury are established or strengthened;

(2) to continue and, if necessary, to strengthen their commitments under the Convention on the Rights of the Child (1989) to respect, protect and fulfil the rights of children to the highest attainable standard of health and to take all appropriate legislative, administrative, social and educational measures to protect children from injury;

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

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

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

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

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

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

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

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

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

2. REQUESTS the Director-General:

(1) to collaborate with Member States in improving data collection and analysis systems for child injuries and in establishing science-based public health policies and programmes for preventing and mitigating the consequences of child injury;

(2) to collaborate with organizations of the United Nations system, international development partners and nongovernmental organizations in order to establish a mechanism for the communication and sharing of information on child injury and of child injury prevention activities, so as to guarantee the cooperation and coordination of all parties concerned;

(3) to encourage research that expands the evidence base for interventions to prevent child injuries and mitigate their consequences, and that evaluates the effectiveness of such interventions through collaborating centres and other partners, including translation into affordable safety products, policy interventions and effective implementation;

(4) to facilitate the adaptation and transfer of knowledge on measures and instruments to prevent child injury, from developed to developing settings;

(5) to support Member States in developing and implementing child injury prevention measures;

(6) to provide additional support to national injury prevention focal persons by organizing regular global and regional meetings and providing technical assistance;

(7) to provide technical support for strengthening systems and capacities for emergency and rehabilitation services;

(8) to collaborate with Member States, organizations in the United Nations system, and international development partners and nongovernmental organizations in order to mobilize resources and to augment the capacities needed to prevent child injury and undertake related rehabilitation programmes; to organize advocacy activities for governments of Member States; and to raise awareness that, in the absence of urgent action, this problem will hamper attainment of the Millennium Development Goals, particularly in developing, low- and middle-income countries where there exists a significant burden of child injuries;¹

¹ Note from WHO Secretariat: The *World report on child injury prevention* provides the following data. Mortality for under 20 year-olds in the South-East Asia and African regions combined totalled 558 000 deaths out of the total of 950 366 deaths reported worldwide.

(9) to invest more in building institutional and individual capacities among Member States so that they are able to develop cost-effective interventions at national and subnational levels;

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

(Twelfth meeting, 24 January 2011)

EB128.R16 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, Lifting The Burden; Stichting Global Initiative on Psychiatry – an International Foundation for the Promotion of Humane, Ethical, and Effective Mental Health Care;³ and The Cochrane Collaboration;
2. DECIDES to discontinue official relations with the Association of the Institutes and Schools of Tropical Medicine in Europe; Commonwealth Association for Health and Disability; International Association of Medical Regulatory Authorities; International Non Governmental Coalition Against Tobacco; International Organization against Trachoma; International Union for Conservation of Nature and Natural Resources; Soroptimist International; and the World Organization of the Scout Movement.

(Twelfth meeting, 24 January 2011)

¹ See Annex 3, and Annex 4 for the financial and administrative implications for the Secretariat of adoption of this resolution.

² Document EB128/28.

³ Known as the Global Initiative on Psychiatry.

DECISIONS

EB128(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 resolution EB126.R17 and decision EB126(5), reached the decisions set out below.

Noting with appreciation their collaboration with WHO and commending their 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.²

Noting the reports concerning their relations with WHO, the Board decided to defer the review of relations with the International Council of Women, La Leche League International and the International Special Dietary Foods Industries until its 130th session. In addition, the Board decided to request, as appropriate, a clarification of the status of relations and reports on the outcome of efforts to agree plans for collaboration, for reporting to the Board at its 130th session.

Noting the successful efforts to agree plans of collaboration, the Board decided to maintain in official relations with WHO the International Association of Hydatid Disease, the International Federation of Clinical Chemistry and Laboratory Medicine, and the International Society for Telemedicine & eHealth.

Noting that exchanges continued with regard to agreement on a plan for collaboration, the Board decided to defer the review of relations with the International Federation of Biomedical Laboratory Science for an additional year. The review of relations would be submitted to the Board at its 130th session.

(Twelfth meeting, 24 January 2011)

EB128(2) Award of the Dr A.T. Shousha Foundation Prize

The Executive Board, having considered the report of the Dr A.T. Shousha Foundation Prize Committee, awarded the Dr A.T. Shousha Foundation Prize for 2011 to Professor Amjad Daoud Niazi from Iraq for his significant contribution to public health in Iraq. The laureate will receive the equivalent of 2500 Swiss francs in United States dollars.

(Twelfth meeting, 24 January 2011)

¹ See Annex 3.

² See document EB128/28.

EB128(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 2011 to both Dr Eva Siracká of Slovakia, and the *Fraternidad Pequeña Familia de María – Albergue de María*, of Panama for their outstanding innovative work in health development. Dr Siracká, as an individual candidate, will receive US\$ 30 000, and the laureate *Fraternidad Pequeña Familia de María – Albergue de María*, as an organization, will receive US\$ 40 000.

(Twelfth meeting, 24 January 2011)

EB128(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 2011 to both Aged Care Maldives and the Association Tchadienne Communauté pour le Progrès for their outstanding contributions to health development. The laureates will each receive US\$ 20 000.

(Twelfth meeting, 24 January 2011)

EB128(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 for 2011 to both Mr Wang Dechen of China and to the Association Tchadienne Communauté pour le Progrès for their outstanding contributions to research in health promotion. The laureates will each receive US\$ 20 000.

(Twelfth meeting, 24 January 2011)

EB128(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 Prize Selection Panel, awarded the Dr LEE Jong-wook Memorial Prize for 2011 to the Clodomiro Picado Institute of Costa Rica for its outstanding contribution to the control of neglected tropical diseases. The laureate will receive US\$ 85 000.

(Twelfth meeting, 24 January 2011)

EB128(7) Amendments to the Statutes of the Dr LEE Jong-wook Memorial Prize for Public Health

In accordance with the provisions of Article 10 of the Statutes of the Dr LEE Jong-wook Memorial Prize for Public Health, the Executive Board approved the recommendation of the Dr LEE Jong-wook Memorial Prize Selection Panel that Articles 2, 3 and 4 of the Statutes of the Dr LEE Jong-wook Memorial Prize for Public Health be revised in order to: (i) take into account a change in the name of the Founder; (ii) increase the amount of the Prize from US\$ 85 000 to US\$ 100 000 and modify accordingly the annual endowment referred to in Article 3 of the Statutes; and (iii) broaden the scope of the purpose of the Prize by providing that it will reward an outstanding contribution made to public health.

(Twelfth meeting, 24 January 2011)

EB128(8) Provisional agenda for, and duration of, the Sixty-fourth World Health Assembly

The Executive Board, having considered the report of the Director-General on the provisional agenda for the Sixty-fourth World Health Assembly,¹ and recalling its earlier decision that the Sixty-fourth World Health Assembly should be held at the Palais des Nations in Geneva, opening on Monday, 16 May 2011, and closing no later than Tuesday, 24 May 2011,² approved the provisional agenda of the Sixty-fourth World Health Assembly, as amended.

(Twelfth meeting, 24 January 2011)

EB128(9) Appointment of representatives of the Executive Board at the Sixty-fourth World Health Assembly

Further to decision EB127(7) of 22 May 2010, and in accordance with paragraph 1 of resolution EB59.R7, the Executive Board appointed its Chairman, Dr M. Kőkény (Hungary), ex officio, and its first three Vice-Chairmen, Dr P.M. Buss (Brazil), Mr P.D.A. Yusof (Brunei Darussalam) and Dr A.J. Mohamed (Oman), to represent the Executive Board at the Sixty-fourth World Health Assembly. It was understood that, if any of those members were not available for the Health Assembly, the other Vice-Chairman, Professor A.F.M.R. Haque (Bangladesh) and the Rapporteur, Dr A. Djibo (Niger), could be asked to represent the Board.

(Twelfth meeting, 24 January 2011)

EB128(10) Date and place of the 129th session of the Executive Board

The Executive Board decided that its 129th session should be convened on Wednesday, 25 May 2011, in Geneva.

(Twelfth meeting, 24 January 2011)

¹ Document EB128/30 Rev.1.

² See decision EB127(9).

ANNEXES

ANNEX 1

Amendments to the Financial Regulations¹

[EB128/26 – 10 November 2010;
EB128/26 Corr.1 – 25 November 2010]

1. At its 124th session in January 2009, 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 amendments would move WHO towards full implementation of the International Public Sector Accounting Standards (IPSAS). The Health Assembly endorsed the introduction of IPSAS in resolution WHA60.9, in line with the introduction of IPSAS throughout the United Nations system.
2. WHO has already adopted many individual standards as required within the United Nations System Accounting Standards and is committed to implementing IPSAS fully from 1 January 2012. Financial Regulation 13.2 requires financial statements to be prepared annually in accordance with IPSAS (IPSAS 1 paragraph 66). The report by the Director-General to the Sixty-third World Health Assembly on amendments to the Financial Regulations³ noted, inter alia, that annual audit verification is not expressly required by IPSAS, but the United Nations Panel of External Auditors, at its December 2009 meeting, confirmed that all United Nations organizations should adopt annual external audits in order to ensure maximum credibility and transparency of their IPSAS financial statements. Therefore, to complete the adoption of IPSAS, an amendment to the Financial Regulations is required in order to allow for annual rather than biennial audits of WHO's financial statements, starting in January 2012.
3. The amendment required involves Financial Regulations 14.8 and 14.9, which cover the issuance and periodicity of audited financial statements. The Regulation would require the External Auditor to issue an annual report on the audit of the financial statements prepared by the Director-General, transmitting it through the Executive Board to the World Health Assembly [see Appendix 1].
4. It is proposed to have the amendments enter into force on 1 January 2012, in connection with the beginning of the next budget cycle.

ACTION BY THE EXECUTIVE BOARD

5. [This paragraph contained a draft resolution that was adopted at the eighth meeting as resolution EB128.R3.]

¹ Resolution EB128.R3.

² Document EB124/22.

³ Document A63/34.

ANNEX 1

Appendix 1

TEXT OF PROPOSED AMENDMENTS TO THE FINANCIAL REGULATIONS**EXISTING TEXT AS AT 1 JANUARY 2010****PROPOSED REVISED TEXT***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.

14.1 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.~~ **The term of office shall be four years, covering two budgetary periods, and can be renewed once for an additional term of four years.** External Auditor(s) appointed may be removed only by the Assembly

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

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

14.9 The report(s) of the External Auditor(s) shall be transmitted through the Executive Board, together with the audited financial 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.

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

ANNEX 2

Confirmation of amendments to the Staff Rules¹

[EB128/36 – 29 December 2010]

1. Amendments to the Staff Rules made by the Director-General are submitted for confirmation by the Executive Board in accordance with Staff Regulation 12.2.²
2. The amendments described in section I of this document stem from decisions expected to be taken by the United Nations General Assembly at its sixty-fifth session, on the basis of recommendations made by the International Civil Service Commission in its annual report for 2010.³ Should the United Nations General Assembly not approve the Commission's recommendations, an addendum to the present document will be issued.
3. The amendments described in section II of this document are made in the light of experience and in the interest of good human resources management.
4. The amendments for the biennium 2010–2011 involve negligible additional costs under the regular budget; these will be met from the appropriate allocations established for each of the regions and for global and interregional activities, as well as from extrabudgetary sources of funds.
5. The amended Staff Rules are set out in [Appendix 1].
6. Transitional measures, including those designed to provide for the application of the amended Staff Rules to processes under way on the effective date of the amendments, may be decided by the Director-General, as necessary.

I. AMENDMENTS CONSIDERED NECESSARY IN THE LIGHT OF DECISIONS EXPECTED TO BE TAKEN BY THE UNITED NATIONS GENERAL ASSEMBLY AT ITS SIXTY-FIFTH 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 1.37% 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 2011.

¹ See resolutions EB128.R4 and EB128.R5.

² *Basic documents*, 47th ed., Geneva, World Health Organization, 2009.

³ Report of the International Civil Service Commission for 2010. *General Assembly Official Records, Sixty-fifth session, Supplement No. 30* (document A/65/30).

8. Amendments to Appendix 1 of the Staff Rules have been prepared accordingly and are attached [Appendix 1, 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 should recommend to the Sixty-fourth World Health Assembly modifications in the salaries of Assistant Directors-General and Regional Directors. Thus, as from 1 January 2011, the gross salary for Assistant Directors-General and Regional Directors would be US\$ 185 809 per annum, and the net salary US\$ 133 776 (dependency rate) or US\$ 121 140 (single rate).

10. Based on the adjustments to salaries described above, the salary modification to be authorized by the Health Assembly for the Deputy Director-General would entail, as from 1 January 2011, a gross salary of US\$ 204 391 per annum with a corresponding net salary of US\$ 145 854 (dependency rate) or US\$ 131 261 (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 from 1 January 2011, would therefore be US\$ 251 188 per annum gross, US\$ 176 272 net (dependency rate) or US\$ 156 760 net (single rate).

Review of the level of the education grant

12. In considering this matter, the International Civil Service Commission had before it proposals by the Human Resources Network of the United Nations System Chief Executives Board for Coordination for a review of the levels of the education grant on the basis of the analysis of expenditure data on 14 724 claims for the academic year 2008-2009 in the 15 individual countries or currency areas for which the education grant was administered.

13. The Commission decided to recommend to the General Assembly:

(a) that for Austria, Denmark, France, Germany, Italy, Netherlands, Spain, Switzerland, United Kingdom of Great Britain and Northern Ireland, United States of America and the United States dollar area outside the United States, the maximum admissible expenses and the maximum education grant be adjusted as shown in Annex III, Table 1, of its report for 2010;

(b) that for Belgium, Ireland, Japan and Sweden the maximum admissible expenses and maximum education grant remain at the current levels shown in Annex III, Table 2, of its report for 2010;

(c) that for Austria, Belgium, Denmark, France, Germany, Italy, Netherlands, Spain, Sweden, Switzerland, United Kingdom of Great Britain and Northern Ireland, United States and the United States dollar area outside the United States, the normal flat rates for boarding taken into account within the maximum admissible educational expenses and the additional amount for reimbursement of boarding costs over and above the maximum grant payable to staff members at designated duty stations be revised as shown in Annex III, Table 3 of its report for 2010;

(d) that for Ireland and Japan the normal flat rates and the additional flat rates for boarding be maintained at current levels as shown in Annex III, Table 4 of its report for 2010;

- (e) that the special measures for China, Hungary, Indonesia, Romania and the Russian Federation as well as for the eight specific schools in France be maintained;
- (f) that the special measures for Bulgaria be discontinued;
- (g) that all the above-mentioned measures be applicable as from the school year in progress on 1 January 2011; and
- (h) in regard to all other proposals, the Commission agreed to defer its decisions, and requested its secretariat to take them into consideration in the context of the next methodology review.

14. Amendments to Appendix 2 of the Staff Rules have been prepared accordingly and are attached [Appendix 1, Attachment 2].

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

Amendments to the Staff Rules

Post classification

15. Staff Rule 210 has been amended for the purpose of clarification and to include a reference to human resources plans. The reference to qualifications has been deleted as this is no longer relevant across the International Civil Service Commission's global classification standards.

16. Staff Rule 220 has been amended to clarify that classification must be undertaken using common classification standards. Normally, the Director-General will promulgate the global classification standards approved by the Commission.

17. Staff Rule 230 has been amended to ensure that reclassifications, requested by the supervisor, if approved, are in line with human resources plans. The right of a staff member to request a re-examination of the classification of the post that he or she occupies is preserved. In addition, for editorial reasons, the text has been reordered.

Medical certification and inoculations

18. Staff Rule 430.1 has been amended to clarify that it is a medical report that should be sent to the Organization's Staff Physician upon the selection of a candidate and before an offer of appointment is made.

19. Staff Rule 430.2 has been amended to clarify that, based on the medical report provided for in Staff Rule 430.1, medical clearance from the Staff Physician is required before an offer of appointment can be made.

20. Staff Rule 430.3 is amended to ensure that staff members obtain the necessary preventive medical treatment required prior to travelling or taking up a new appointment.

21. Staff Rule 430.6 has been amended to indicate that there is a financial limit to requests for reimbursement of medical examinations required by the Organization.

Promotion

22. Staff Rule 560.3 has been amended to ensure the best matching of incumbent and position by advertising those posts that have previously been reclassified with the same incumbent. An amendment has also been made to clarify that the professional category includes both national and international professional staff members.

Reassignment

23. An editorial change has been made to Staff Rule 565.3 in order to ensure greater clarity.

Annual leave

24. Staff Rule 630.7 has been amended to require a staff member who is ill during a period of annual leave and who requests the leave to be converted to sick leave to submit a medical report, rather than a medical certificate, for review and approval by WHO.

Leave without pay

25. Staff Rule 655.2.3 has been amended to align the text with the requirement in Staff Rule 420.2 that a fixed-term staff member qualifies for a continuing appointment only when he or she has completed five years' uninterrupted, active service on fixed-term appointments. The amendment clarifies that during periods when a staff member is on leave without pay of more than 30 calendar days, no service credits accrue for the purpose of the granting of a continuing appointment.

Sick leave

26. Staff Rule 740.1 has been amended to align the Organization's practice with that of other organizations of the United Nations common system, emphasizing that the Organization is the approving authority for sick leave absence.

27. Staff Rule 740.2 has been amended to clarify that medical reports are required for periods of work incapacity that exceed one month. This will ensure that medical follow-up is conducted, and the corresponding documentation issued, on a regular basis.

28. Staff Rule 740.3 has been amended to emphasize that medical reports are required for continued periods of incapacity and that the Staff Physician may require a staff member to be examined by a designated physician. These amendments are in the interest of staff well-being, to facilitate identification of medical needs and, where appropriate, facilitate the return to work.

29. The current text of Staff Rule 740.5 has been moved and renumbered as a new Rule 740.6.

30. New Staff Rule 740.5 has been introduced to ensure that staff members on extended work incapacity have the approval of the Staff Physician prior to travelling from the duty station. Such notification will facilitate the medical follow-up of staff members on extended sick leave absence and align the Organization's Rules with those of other organizations of the United Nations common system.

31. The current text of Staff Rule 740.6 has been moved and re-numbered as new Rule 740.7.

Sick leave under insurance cover

32. Staff Rule 750.2 has been amended to align the text with the requirement in Staff Rule 420.2 that a fixed-term staff member qualifies for a continuing appointment only when he or she has completed five years' uninterrupted, active service on fixed-term appointments. The amendment clarifies that during periods when a staff member is on sick leave under insurance coverage of more than 30 days, no service credits accrue for the purpose of the award of a continuing appointment.

33. New Staff Rule 750.3 has been introduced to reflect consistency with the change to Staff Rule 740.5 and to ensure that staff members on sick leave under insurance coverage obtain clearance from the Staff Physician prior to travelling from the duty station. Such requirements are necessary to facilitate the medical follow-up of staff members on extended sick leave absences and align the Organization's Rules with those of other organizations of the United Nations common system.

Abolition of post

34. Staff Rules 1050.2, 1050.3 and 1050.4 have been amended and reordered to clarify the text. Principle and process were previously mixed together. The "paramount consideration" referred to in the previous version of Staff Rule 1050.2.2 has been moved up to its own paragraph (Rule 1050.3) in order to highlight its overarching importance.

35. Staff Rule 1050.5 has been deleted as it is now obsolete. The right of a staff member to participate in a reassignment process referred to under Staff Rule 1050.2 is no longer linked to the type of position to which a staff member is assigned, but rather to the type of appointment and the duration of service.

36. Staff Rule 1050.8 (former Staff Rule 1050.2.9) has been revised in light of experience to highlight the implications of refusing a reassignment.

ACTION BY THE EXECUTIVE BOARD

37. [This paragraph contained two draft resolutions, which were adopted at the eighth meeting as resolutions EB128.R4 and EB128.R5, respectively.]

Appendix 1

TEXT OF AMENDED STAFF RULES

210. POST CLASSIFICATION

The Director-General shall establish and approve human resources plans in the Global Management System which will include the classification of all posts in the Organization according to the type and level of the duties and responsibilities of the posts.

.....

220. CLASSIFICATION OF INDIVIDUAL POSTS

All posts, other than those at the Ungraded levels, shall be classified in categories and level according to standards promulgated by the Director-General and related to the nature of the duties and the level of responsibilities required.

.....

230. CLASSIFICATION REVIEW

In accordance with procedures established by the Director-General, a staff member may request a re-examination of the classification of any post under his supervision and with reference to the approved human resources plan. A staff member may request a re-examination of the classification of the post which he occupies.

.....

430. MEDICAL CERTIFICATION AND INOCULATIONS

430.1 Upon selection an appointee shall undergo a prescribed medical examination by a physician designated by the Organization, whose medical report shall be forwarded to the Organization’s Staff Physician.

430.2 Before an offer of appointment can be made, medical clearance must be issued by the Staff Physician; medical clearance is based on the examination required in Rule 430.1. Should the result of the examination show that the standards required by the Organization are not met, a decision shall be made whether or not to make an offer of appointment and, if an offer is to be made, upon what terms.

430.3 Upon appointment and before any subsequent travel for the Organization, a staff member shall have such inoculations and preventive treatment as the Staff Physician shall prescribe.

430.6 Any medical examination and any inoculation required by the Organization shall be at its expense, subject to limits established by the Director-General.

.....

560. PROMOTION

...

560.3 If an occupied post is reclassified from the general service category to a professional category or by more than one grade within a category, or if the post has been reclassified previously while occupied by the same incumbent, the post shall be announced to the staff and selection for that post shall be on a competitive basis, subject to conditions to be determined by the Director-General. In such cases, the staff member with a continuing or fixed-term appointment occupying the advertised post may be granted extra pay as from the fourth consecutive month of the effective date of the reclassification calculated in accordance with the provisions of, and with due regard to, the period specified in Rule 320.4.

[No further changes]

.....

565. REASSIGNMENT

...

565.3 So far as practicable, and in the interest of developing a versatile career workforce, vacancies in posts in the professional category and above shall be filled by the reassignment of staff members with continuing or fixed-term appointments between the different activities and offices of the Organization. In accepting appointment, a staff member with a continuing or fixed-term appointment accepts the applicability of this policy to himself.

[No further changes]

.....

630. ANNUAL LEAVE

...

630.7 A staff member who is ill during a period of annual leave shall, subject to the provisions of Rule 740, have that portion of his absence considered as sick leave upon presentation of a satisfactory medical report and approval by WHO.

[No further changes]

655. LEAVE WITHOUT PAY

...

655.2 During any leave without pay under Rule 655.1, the following conditions shall apply:

655.2.1 [no change]

655.2.2 [no change]

655.2.3 no service credit shall accrue for the purposes of annual leave, a within-grade increase, completion of probation, a continuing appointment, repatriation grant, termination indemnity, home leave, meritorious increases under Rule 555.2, and end-of-service grant. Periods of leave without pay of 30 calendar days or less shall not affect the ordinary rates of accrual;

[No further changes]

.....
740. SICK LEAVE

740.1 Staff members, except those excluded by the Director-General under the provisions of Rule 1320 who are unable to perform their duties because of illness or injury, or whose attendance is prevented by public health requirements, may be granted sick leave with pay with the approval by WHO in the following amounts:

[No further changes to Rule 740.1]

740.2 Any absence of more than three consecutive working days which is to be charged as sick leave must be supported by a certificate from a duly recognized medical practitioner stating that the staff member is unable to perform his duties and indicating the probable duration of the work incapacity. Where the work incapacity continues beyond one month, a medical report from the treating physician is required. Not more than seven working days of uncertified absences within one calendar year shall be charged to sick leave. Part or all of this uncertified sick leave may be granted to attend to serious family-related emergencies in which case the certification requirement in respect of three consecutive working days shall not apply.

740.3 In any case of a staff member's claiming sick leave, he shall submit such periodic medical reports on his condition as the Staff Physician shall require and shall be examined by the Staff Physician, or by a physician designated by the Staff Physician, if the Staff Physician so decides.

740.4 [No change]

740.5 A staff member on sick leave may not leave the duty station without prior approval of the Staff Physician or a physician designated by the Staff Physician.

740.6 The termination of a staff member's appointment shall, from the date it is effective, terminate any claim to sick leave under these Rules.

740.7 Upon the recommendation of the Staff Physician, the Director-General may require a staff member to absent himself on sick leave.

.....

750. SICK LEAVE UNDER INSURANCE COVER

750.2 During sick leave under insurance cover no service credit shall accrue for the purposes of annual leave, a within-grade increase, completion of probation, a continuing appointment, repatriation grant, termination indemnity, home leave and end-of-service grant. Periods of 30 calendar days or less shall not affect the ordinary rates of accrual.

750.3 A staff member on sick leave under insurance cover may not leave the duty station without prior approval of the Staff Physician or a physician designated by the Staff Physician.

.....

1050. ABOLITION OF POST

1050.2 When a post held by a staff member with a continuing appointment, or by a staff member who has served on a fixed-term appointment for a continuous and uninterrupted period of five years or more, is abolished or comes to an end, reasonable efforts shall be made to reassign the staff member occupying that post, in accordance with procedures established by the Director-General.

1050.3 The paramount consideration for reassignment shall be the necessity of securing the highest standards of efficiency, competence and integrity with due regard given to the performance, qualifications and experience of the staff member concerned.

1050.4 The Director-General may establish priorities for reassigning staff members.

1050.5 The reassignment process shall be coordinated by a Reassignment Committee established by the Director-General as follows:

1050.5.1 the process will extend to all offices if the abolished post is in the professional category or above; if the abolished post is subject to local recruitment, the reassignment process shall be limited to the locality of the abolished post;

1050.5.2 staff members shall be given due preference for vacancies during the reassignment period, within the context of Staff Rule 1050.3;

1050.5.3 staff members may be reassigned to vacant posts at the same grade as the post to be abolished, or one grade lower.

- 1050.6 The reassignment period will end within six months from its commencement. This period may only be exceptionally extended by the Director-General for up to an additional six months.
- 1050.7 During the reassignment period, the staff member may be provided with training to enhance specific existing qualifications.
- 1050.8 The staff member's appointment shall be terminated if no reassignment decision is made during the reassignment period or if the staff member refuses a reassignment pursuant to Staff Rule 1050.5.3.
- 1050.9 [No further change]
- 1050.10 [No further change]
-

ATTACHMENT 1
Appendix 1 to the Staff Rules

**Salary scale for staff in the professional and higher graded categories: annual gross base salaries and net equivalents after application of staff assessment (in US dollars)¹
(effective 1 January 2011)**

| Level | Step | | | | | | | | | | | | | | | |
|---------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|--|
| | <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 | 152 231 | 155 592 | 158 954 | 162 315 | 165 675 | 169 035 | | | | | | | | | | |
| Net D | 111 950 | 114 135 | 116 320 | 118 505 | 120 689 | 122 873 | | | | | | | | | | |
| Net S | 102 847 | 104 691 | 106 528 | 108 359 | 110 186 | 112 002 | | | | | | | | | | |
| | | | | | * | * | * | * | * | | | | | | | |
| P-6/D-1 Gross | 139 074 | 141 896 | 144 710 | 147 532 | 150 371 | 153 320 | 156 272 | 159 222 | 162 171 | | | | | | | |
| Net D | 103 070 | 104 989 | 106 903 | 108 822 | 110 741 | 112 658 | 114 577 | 116 494 | 118 411 | | | | | | | |
| Net S | 95 270 | 96 936 | 98 600 | 100 258 | 101 915 | 103 567 | 105 212 | 106 857 | 108 497 | | * | * | * | | | |
| | | | | | | | | | | | | | | | | |
| P-5 Gross | 115 134 | 117 532 | 119 934 | 122 331 | 124 732 | 127 129 | 129 531 | 131 929 | 134 329 | 136 729 | 139 129 | 141 528 | 143 929 | | | |
| Net D | 86 791 | 88 422 | 90 055 | 91 685 | 93 318 | 94 948 | 96 581 | 98 212 | 99 844 | 101 476 | 103 108 | 104 739 | 106 372 | | | |
| Net S | 80 629 | 82 079 | 83 524 | 84 969 | 86 412 | 87 849 | 89 286 | 90 720 | 92 152 | 93 581 | 95 008 | 96 431 | 97 853 | | | |
| | | | | | | | | | | | | | | * | * | |
| P-4 Gross | 94 268 | 96 456 | 98 642 | 100 876 | 103 194 | 105 507 | 107 825 | 110 140 | 112 456 | 114 768 | 117 087 | 119 399 | 121 715 | 124 032 | 126 349 | |
| Net D | 72 373 | 73 948 | 75 522 | 77 096 | 78 672 | 80 245 | 81 821 | 83 395 | 84 970 | 86 542 | 88 119 | 89 691 | 91 266 | 92 842 | 94 417 | |
| Net S | 67 395 | 68 829 | 70 263 | 71 691 | 73 120 | 74 548 | 75 975 | 77 399 | 78 822 | 80 244 | 81 664 | 83 083 | 84 502 | 85 918 | 87 334 | |
| | | | | | | | | | | | | | | * | * | |
| P-3 Gross | 77 101 | 79 125 | 81 150 | 83 172 | 85 199 | 87 222 | 89 244 | 91 272 | 93 296 | 95 319 | 97 346 | 99 367 | 101 476 | 103 618 | 105 759 | |
| Net D | 60 013 | 61 470 | 62 928 | 64 384 | 65 843 | 67 300 | 68 756 | 70 216 | 71 673 | 73 130 | 74 589 | 76 044 | 77 504 | 78 960 | 80 416 | |
| Net S | 56 018 | 57 358 | 58 701 | 60 040 | 61 382 | 62 721 | 64 060 | 65 403 | 66 741 | 68 082 | 69 418 | 70 755 | 72 089 | 73 426 | 74 762 | |
| | | | | | | | | | | | | * | | | | |
| P-2 Gross | 62 856 | 64 668 | 66 476 | 68 289 | 70 100 | 71 908 | 73 721 | 75 528 | 77 340 | 79 153 | 80 961 | 82 774 | | | | |
| Net D | 49 756 | 51 061 | 52 363 | 53 668 | 54 972 | 56 274 | 57 579 | 58 880 | 60 185 | 61 490 | 62 792 | 64 097 | | | | |
| Net S | 46 669 | 47 853 | 49 032 | 50 214 | 51 394 | 52 576 | 53 778 | 54 975 | 56 178 | 57 377 | 58 574 | 59 776 | | | | |
| | | | | | | | | | | | | | | | | |
| P-1 Gross | 48 627 | 50 199 | 51 933 | 53 678 | 55 414 | 57 154 | 58 896 | 60 638 | 62 374 | 64 114 | | | | | | |
| Net D | 39 388 | 40 643 | 41 892 | 43 148 | 44 398 | 45 651 | 46 905 | 48 159 | 49 409 | 50 662 | | | | | | |
| Net S | 37 154 | 38 309 | 39 465 | 40 618 | 41 773 | 42 926 | 44 081 | 45 222 | 46 356 | 47 491 | | | | | | |

¹D = 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 2011)

| <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) |
|---|--|--------------------------------------|---|---|---|--|
| Part A | | | | | | |
| Euro | | | | | | |
| Austria | 17 555 | 13 166 | 3 776 | 5 664 | 18 830 | 12 520 |
| Belgium | 15 458 | 11 593 | 3 518 | 5 277 | 16 771 | 10 767 |
| France* | 10 981 | 8 236 | 3 052 | 4 578 | 12 814 | 6 912 |
| Germany | 19 563 | 14 672 | 4 221 | 6 332 | 21 004 | 13 935 |
| Ireland | 17 045 | 12 784 | 3 112 | 4 668 | 17 452 | 12 896 |
| Italy | 20 830 | 15 623 | 3 147 | 4 721 | 20 344 | 16 635 |
| Luxembourg | 15 458 | 11 593 | 3 518 | 5 277 | 16 771 | 10 767 |
| Monaco | 10 981 | 8 236 | 3 052 | 4 578 | 12 814 | 6 269 |
| Netherlands | 17 512 | 13 134 | 3 875 | 5 813 | 18 947 | 12 345 |
| Spain | 16 653 | 12 490 | 3 162 | 4 743 | 17 233 | 12 437 |
| Denmark (krone) | 113 554 | 85 166 | 27 242 | 40 863 | 126 029 | 77 232 |
| Japan yen (yen) | 2 324 131 | 1 743 098 | 607 703 | 911 555 | 2 654 653 | 1 513 860 |
| Sweden (krona) | 157 950 | 118 462 | 26 034 | 39 051 | 157 513 | 123 237 |
| Switzerland (Swiss franc) | 31 911 | 23 933 | 5 540 | 8 310 | 32 243 | 22 524 |
| United Kingdom of Great Britain and Northern Ireland (pound sterling) | 24 941 | 18 706 | 3 690 | 5 535 | 24 241 | 20 021 |
| Part B | | | | | | |
| United States dollar (outside the United States of America) | 20 663 | 15 497 | 3 746 | 5 619 | 21 116 | 15 668 |
| Part C | | | | | | |
| United States dollar (in the United States) ¹ | 43 006 | 32 255 | 6 083 | 9 125 | 41 380 | 34 896 |

* 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. École Active Bilingue Jeannine Manuel

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.

** 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 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).

ANNEX 3

Nongovernmental organizations, admitted into, or maintained in official relations with WHO by virtue of, respectively, resolution EB128.R16 and decision EB128(1)

Alzheimer's Disease International¹
Corporate Accountability International¹
European Generic Medicines Association¹
Family Health International¹
HelpAge International¹
Inclusion International¹
Industry Council for Development¹
Inter-African Committee on Traditional Practices affecting the Health of Women and Children¹
International Association for Child and Adolescent Psychiatry and Allied Professions¹
International Association for Suicide Prevention¹
International Association for the Scientific Study of Intellectual Disabilities¹
International Association for the Study of Obesity¹
International Association of Hydatid Disease
International Bureau for Epilepsy¹
International Centre for Trade and Sustainable Development¹
International Commission on Occupational Health¹
International Confederation of Midwives¹
International Council for Control of Iodine Deficiency Disorders¹
International Council of Women
International Ergonomics Association¹
International Federation of Biomedical Laboratory Science
International Federation of Business and Professional Women (BPW International)¹
International Federation of Clinical Chemistry and Laboratory Medicine
International Federation of Gynecology and Obstetrics¹
International Federation on Ageing¹
International Lactation Consultant Association¹
International League Against Epilepsy¹
International Network of Women Against Tobacco¹
International Occupational Hygiene Association¹
International Pediatric Association¹
International Physicians for the Prevention of Nuclear War¹
International Planned Parenthood Federation¹
International Society for Biomedical Research on Alcoholism¹
International Society for Prosthetics and Orthotics¹
International Society for Telemedicine & eHealth
International Society of Andrology¹
International Society of Physical and Rehabilitation Medicine¹
International Special Dietary Foods Industries

¹ Activities concern the period 2008–2010.

International Union for Health Promotion and Education¹
International Union of Nutritional Sciences¹
International Union of Psychological Science¹
International Women's Health Coalition Inc.¹
Italian Association of Friends of Raoul Follereau¹
La Leche League International
Lifting the Burden
Medical Women's International Association¹
MSF International¹
Multiple Sclerosis International Federation¹
Rehabilitation International¹
Stichting Global Initiative on Psychiatry – an International Foundation for the Promotion of Humane,
Ethical and Effective Mental Health Care throughout the World²
Stichting Health Action International¹
The Cochrane Collaboration
The International Alliance of Women: Equal Rights-Equal Responsibilities¹
The International Society for the Prevention of Child Abuse and Neglect¹
The Population Council, Inc.¹
World Association for Psychosocial Rehabilitation¹
World Association for Sexual Health¹
World Confederation for Physical Therapy¹
World Federation for Mental Health¹
World Federation of Neurology¹
World Federation of Neurosurgical Societies¹
World Federation of Occupational Therapists¹
World Federation of the Deaf¹
World Psychiatric Association¹

¹ Activities concern the period 2008–2010.

² Known as the Global Initiative on Psychiatry.

ANNEX 4

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

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| <p>1. Resolution EB128.R1 WHO's role in the follow-up to the United Nations High-level Plenary Meeting of the General Assembly on the Millennium Development Goals (New York, September 2010)</p> | | |
| <p>2. Linkage to programme budget</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; border: none;"> <p>Strategic objective:</p> <p>10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.</p> </td> <td style="width: 50%; vertical-align: top; border: none;"> <p>Organization-wide expected result:</p> <p>10.4 Country health-information systems that provide and use high-quality and timely information for health planning and for monitoring progress towards national and major international goals strengthened.</p> <p>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.</p> <p>10.11 Norms, standards and measurement tools developed for tracking resources, estimating the economic consequences of illness, and the costs and effects of interventions, financial catastrophe, impoverishment, and social exclusion, and their use supported and monitored.</p> </td> </tr> </table> <p style="text-align: center;">(Briefly indicate the linkage with expected results, indicators, targets, baseline)</p> <p>The support to the work of the Commission on Information and Accountability for Women's and Children's Health is expected to:</p> <ul style="list-style-type: none"> • lead to better knowledge and evidence for health decision-making at country and global levels (expected result 10.5) • contribute to strengthening of country health information systems (expected result 10.4) • improved tracking of resources at country and global levels (expected result 10.11). <p>Using the current indicators, results of implementation can best be measured through the proportion of low- and middle-income countries with adequate monitoring of the health-related Millennium Development Goals that meet agreed standards (indicator 10.4.1). Currently, 40% of countries meet standards; the target is 60% by 2013.</p> | <p>Strategic objective:</p> <p>10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.</p> | <p>Organization-wide expected result:</p> <p>10.4 Country health-information systems that provide and use high-quality and timely information for health planning and for monitoring progress towards national and major international goals strengthened.</p> <p>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.</p> <p>10.11 Norms, standards and measurement tools developed for tracking resources, estimating the economic consequences of illness, and the costs and effects of interventions, financial catastrophe, impoverishment, and social exclusion, and their use supported and monitored.</p> |
| <p>Strategic objective:</p> <p>10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.</p> | <p>Organization-wide expected result:</p> <p>10.4 Country health-information systems that provide and use high-quality and timely information for health planning and for monitoring progress towards national and major international goals strengthened.</p> <p>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.</p> <p>10.11 Norms, standards and measurement tools developed for tracking resources, estimating the economic consequences of illness, and the costs and effects of interventions, financial catastrophe, impoverishment, and social exclusion, and their use supported and monitored.</p> | |
| <p>3. Budgetary implications</p> <p>(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).</p> <p>US\$ 2.5 million for provision of technical and administrative support to the Commission.</p> | | |

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| <p>(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).</p> <p>US\$ 2.5 million at headquarters.</p> <p>(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?</p> <p>No.</p> |
| <p>4. Financial implications</p> <p>How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?</p> <p>Specified voluntary contributions provided by Member States for the work of the Commission.</p> |
| <p>5. Administrative implications</p> <p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).</p> <p>Headquarters level.</p> <p>(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.</p> <p>The resolution can be implemented by existing staff.</p> <p>(c) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile).</p> <p>Not applicable.</p> <p>(d) Time frames (indicate broad time frames for implementation of activities).</p> <p>From January 2011 to September 2011.</p> |

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| 1. Resolution EB128.R3 Amendments to the Financial Regulations | |
| 2. Linkage to programme budget | |
| Strategic objective: | Organization-wide expected result: |
| 13. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively. | 13.5 Managerial and administrative support services ¹ necessary for the efficient functioning of the Organization provided in accordance with service-level agreements that emphasize quality and responsiveness. |
| (Briefly indicate the linkage with expected results, indicators, targets, baseline) | |
| The resolution links with the statutory External Audit of WHO and the certification of the Organization's accounts. The intended outcome is an unqualified audit opinion. | |

¹ Includes services in the areas of information technology, human resources, financial resources, logistics and language services.

3. Budgetary implications

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

The requirement for the External Auditor to issue a report on the audit of the annual financial statements is estimated to entail an additional cost of between US\$ 100 000 and US\$ 200 000 per biennium. The amount will be known when nominations are received for the post of External Auditor for the period of two bienniums 2012–2015 early in 2011, and once the External Auditor has been appointed by the Health Assembly in May 2011.

- (b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000, including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).**

None.

- (c) Is the estimated cost noted in (b) included within the existing approved Programme budget for the biennium 2010–2011?**

Not applicable.

4. Financial implications

- How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?**

Through the regular budget or administrative overheads (programme support costs on voluntary contributions or the post occupancy charge).

5. Administrative implications

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

Implementation activities will principally concern headquarters and the Global Service Centre; the administered entities – UNAIDS, IARC, the International Computing Centre and the International Drug Purchase Facility, UNITAID – will also require yearly certification audits of their accounts. The change in the Financial Regulations should not affect the frequency of regional audits.

- (b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.**

No additional staff will be needed, although the External Auditor will require additional resources.

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

See 5(b) above.

- (d) Time frames (indicate broad time frames for implementation).**

The first annual certification audit will encompass WHO's financial statements for 2012.

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| 1. Resolution EB128.R4 Confirmation of amendments to the Staff Rules | |
| 2. Linkage to programme budget | |
| Strategic objective: | Organization-wide expected result: |
| 13. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively. | 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 outlined in the report ¹ 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-fifth session. ² 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. Budgetary implications | |
| (a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities). | |
| (i) Remuneration of staff in the professional and higher categories Base/floor salary scale | |
| The financial implications of increasing the base/floor salary scale as shown in document EB128/36 are estimated at approximately US\$ 46 900 per annum. | |
| (ii) Education grant levels | |
| The financial implications associated with the recommendations regarding the education grant are estimated at US\$ 197 400 per annum. | |
| (iii) Children's and secondary dependants' allowances | |
| The financial implications associated with the recommendations regarding the children's and secondary dependants' allowances are estimated at US\$ 273 000 per annum. | |
| (b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant). | |
| As implementation takes place as of 1 January 2011, the costs referred to above apply to the biennium 2010–2011. They will be incurred at all levels of the Organization. | |
| (c) Is the estimated cost noted in (b) included within the existing approved Programme budget for the biennium 2010–2011? | |
| All of the costs are included in the existing approved programme budget. | |

¹ Document EB128/36.

² Report of the International Civil Service Commission for 2010. *General Assembly Official Records, Sixty-fifth session, Supplement No. 30* (document A/65/30).

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| <p>4. Financial implications</p> <p>How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?</p> <p>Extrabudgetary sources of funding will be mobilized where required.</p> |
| <p>5. Administrative implications</p> <p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).</p> <p>All levels of the Organization will be involved.</p> <p>(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.</p> <p>Yes.</p> <p>(c) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile).</p> <p>The amendments do not require additional staffing.</p> <p>(d) Time frames (indicate broad time frames for implementation of activities).</p> <p>Implementation will take place from 1 January 2011.</p> |

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| 1. Resolution EB128.R6 Eradication of dracunculiasis | |
| 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 will provide the framework for increasing the number of countries and territories certified for eradication of dracunculiasis from 187 in 2010 to 193 by 2013. | |
| 3. Budgetary implications | |
| (a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities). | |
| US\$ 30 million over the envisaged life-cycle of this resolution of five years (2011–2015). | |
| (b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant). | |
| US\$ 12.74 million. The costs will be incurred at headquarters, the regional offices for Africa and for the Eastern Mediterranean and country offices. | |

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| <p>(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?</p> <p>Yes.</p> |
| <p>4. Financial implications</p> <p>How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?</p> <p>Existing extrabudgetary sources.</p> |
| <p>5. Administrative implications</p> <p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).</p> <p>Headquarters, the regional offices for Africa and for the Eastern Mediterranean and countries therein.</p> <p>(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.</p> <p>Yes.</p> <p>(c) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile).</p> <p>None.</p> <p>(d) Time frames (indicate broad time frames for implementation of activities).</p> <p>2011–2015.</p> |

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| 1. Resolution EB128.R7 Cholera: mechanism for control and prevention | |
| 2. Linkage to programme budget | |
| <p>Strategic objective:</p> <p>1. To reduce the health, social and economic burden of communicable diseases.</p> <p>5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.</p> <p>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.</p> | <p>Organization-wide expected result:</p> <p>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.</p> <p>1.9 Effective operations and response by Member States and the international community to declared emergency situations due to epidemic and pandemic prone diseases.</p> <p>5.4 Coordinated technical support provided to Member States for communicable disease control in natural disaster and conflict situations.</p> <p>8.1 Evidence-based assessments made, and norms and standards formulated and updated on major environmental hazards to health (e.g. poor air quality, chemical substances, electromagnetic fields, radon, poor quality drinking-water and waste-water reuse).</p> |

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

The resolution is consistent with overall expected results, and with the specific elements noted below.

Baseline: ad hoc support provided to countries and regional offices according to expressed need.

Target: current biennium, develop a medium-term strategy 2011–2016 and a detailed plan of action and necessary tools; start implementation in three regions; biennium 2012–2013, implement plan in three regions with three countries in each; biennium 2014–2015, maintain and scale up activities in three regions and add the three remaining regions.

Indicators:

- (a) information and technical back-up provided to countries affected by outbreaks
- (b) support for each of the participating countries performed as follows:
 - national action plan revised and updated; cholera surveillance within integrated diseases surveillance reviewed in countries
 - “hot spots” and trends over time identified
 - specific needs for preparedness and prevention activities identified, control activities implemented and maintained over time (e.g. health education, food safety, water and sanitation, prepositioning of supplies)
 - assessment for vaccine use performed and, if pertinent, plan for introduction elaborated
 - strategy undertaken for training of trainers, multiplication of national workshops and quality control of capacity-building activities (e.g. in the areas of case management and laboratory capacities)
 - monitoring of performances implemented according to indicators to be identified and developed
- (c) regular meetings with key stakeholders held to review progress and best practice on various topics
- (d) support provided to research activities in risk assessment, vaccine development, and other relevant issues.

3. Budgetary implications

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

Total for five years: US\$ 20 220 000 for staff and activities (programme support costs not included).

- (b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).**

Staffing: US\$ 874 000 at headquarters level and US\$ 606 000 at regional level (Regional offices for Africa, the Americas, and the Eastern Mediterranean).

Activities: US\$ 1 240 000, of which 57% will be incurred at regional level.

- (c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?**

The costs associated with outbreaks could to some degree be included in the existing figures for the approved Programme budget; the extent to which this can be done will depend mainly on the severity or regularity of outbreaks. It is not expected that the costs associated with preventive actions could be considered within the current budget ceilings of the strategic objectives mentioned above.

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| <p>4. Financial implications</p> <p>How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?</p> <p>A medium-term strategy will be developed and will be used for resource mobilization at international and country levels.</p> |
| <p>5. Administrative implications</p> <p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).</p> <p>Global coordination, backstopping and standard-setting at headquarters level; Global Task Force on Cholera Control functioning with participation from all relevant departments. Activities at regional and country levels involving a focus during the first biennium on the African Region, the Region of the Americas and the Eastern Mediterranean Region, scaling up to the South-East Asia, European and Western Pacific regions during successive bienniums.</p> <p>(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.</p> <p>No.</p> <p>(c) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile).</p> <p>Over a five-year period, four additional professional staff will be required at different levels; additional staff at the general service level will also be needed to support existing staff at headquarters. At the regional level, for each region a public health specialist or epidemiologist and a water and sanitation specialist at P4 level would be required.</p> <p>(d) Time frames (indicate broad time frames for implementation of activities).</p> <p>An initial phase of five years.</p> |

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| 1. Resolution EB128.R8 Sustainable health financing structures and universal coverage | |
| 2. Linkage to programme budget | |
| <p>Strategic objective:</p> <p>10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.</p> | <p>Organization-wide expected result:</p> <p>All the Organization-wide expected results under strategic objective 10, particularly:</p> <p>10.10 Evidence-based policy and technical support provided to Member States in order to improve health-system financing in terms of the availability of funds, social and financial-risk protection, equity, access to services and efficiency of resource use.</p> <p>10.11 Norms, standards and measurement tools developed for tracking resources, estimating the economic consequences of illness, and the costs and effects of interventions, financial catastrophe, impoverishment, and social exclusion, and their use supported and monitored.</p> <p>10.12 Steps taken to advocate additional funds for health where necessary; to build capacity in framing of health-financing policy and interpretation and use of financial information; and to stimulate the generation</p> |

and translation of knowledge to support policy development.

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

The resolution provides a framework that will contribute to the achievement of the expected results mentioned above and links to the relevant indicators, targets and baselines.

3. Budgetary implications

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

Implementation of the resolution will entail costs of US\$ 9 million over the next six years, in addition to the cost of US\$ 4.8 million estimated for implementation of resolution WHA62.12. This figure represents the cost of: scaling up technical and policy support to Member States in the area of health financing for universal coverage; linking this effort with national health plans and strategies; and increasing capacity to share experiences across countries.

(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).

All levels of the Organization are currently engaged in the provision of technical support to countries in relation to financing for universal coverage; they all facilitate the sharing of experiences across countries. The cost of scaling up these activities in order to meet the current demand from countries, as well as the need to share across countries information on what has worked and what has not worked, is estimated at US\$ 1.50 million during 2011 (US\$ 1.05 million for the regions and US\$ 450 000 for headquarters).

(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?

Some costs for technical support to countries and information sharing were included in the Programme budget 2010–2011. The costs outlined here are additional costs required to meet the growing demand for countries for this type of support partly in response to *The world health report 2010*.¹

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

A strategy for mobilizing the additional resources required in a resource-constrained environment is being developed.

5. Administrative implications

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

All regions will engage in providing technical support to Member States. Headquarters will support this effort, helping to coordinate increased exchange of information as requested by the resolution – particularly since there is increasing demand for cross-regional exchanges. However, regional and country offices will also be heavily involved in information-exchange activities.

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

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.

In order to meet the expected increase in demand from Member States for this type of support, new staff will be required or existing staff will need to be redeployed. Many regional and country offices do not have sufficient skills in health financing.

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

The costs mentioned above include additional staff in the professional category in the area of health financing policy (1.5 at headquarters and 3 in the regions).

(d) Time frames (indicate broad time frames for implementation of activities).

Health financing systems are always developing so requests for technical support will continue. The time frame for this costing is set at three bienniums (six years).

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| 1. Resolution EB128.R9 Health workforce strengthening | |
| 2. Linkage to programme budget | |
| Strategic objective: | Organization-wide expected result: |
| 10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research. | 10.8 Health-workforce information and knowledge base strengthened, and country capacities for policy analysis, planning, implementation, information-sharing and research built up. |
| | 10.9 Technical support provided to Member States, with a focus on those facing severe health-workforce difficulties in order to improve the production, distribution, skill mix and retention of the health workforce. |
| (Briefly indicate the linkage with expected results, indicators, targets, baseline) | |
| WHO's activities in support of health workforce strengthening have links with strategic objective 10, specifically the two Organization-wide expected results mentioned above. The present resolution is also linked to the implementation of resolution WHA63.16, in which (inter alia) the WHO Global Code of Practice on the International Recruitment of Health Personnel was adopted. | |
| 3. Budgetary implications | |
| (a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities). | |
| US\$ 39 million over a period of six years, beginning 2011. This includes activities at headquarters and in the regions. | |
| (b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant). | |
| US\$ 1.5 million at headquarters level and US\$ 4.5 million at regional level. | |
| (c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011? | |
| A total of US\$ 1 million is included for headquarters and the regions. | |

4. Financial implications**How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?**

Costs will be met through income from core voluntary contributions from Member States and international partners. In line with the implementation strategy for the Code developed by the Secretariat, resource mobilization activities will be undertaken for this area with a particular focus on certain Member States and international partners, since this is a mission-critical activity. Indications of support have already been received from Japan, Norway, the United States of America and the European Union.

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

All levels of the Organization will be involved; however, implementation will particularly concern countries facing major challenges as a result of critical health workforce shortages.

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.

No. Additional staff will be required at headquarters and in the regions.

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

Exact requirements will depend on the intensity of activities. Every effort will be made to make full use of secondments and the deployment of interns, in addition to employing short-term staff.

(d) Time frames (indicate broad time frames for implementation of activities).

An implementation strategy has already been developed by the Secretariat. Activities will be implemented according to this strategy, which covers the period 2011–2015.

1. Resolution EB128.R10 Strengthening national health emergency and disaster management capacities and resilience of health systems**2. Linkage to programme budget**

Strategic objective:

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

Organization-wide expected result:

5.1 Norms and standards developed, capacity built and technical support provided to Member States for the development and strengthening of national emergency preparedness plans and programmes.

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

The establishment and operation of a disaster risk-management and emergency-preparedness platform, together with a functional safe hospitals programme at national level will help significant progress to be made in the area of disaster risk-reduction, and emergency preparedness, response and recovery in countries at risk. The resolution will further strengthen the all-hazards health emergency and disaster risk-management programmes as part of national health systems in order to improve health outcomes, reduce mortality and morbidity, protect investment in health infrastructure and strengthen the resilience of the health system and society at large.

3. Budgetary implications

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

The figures provided concern the period until the end of 2013.

At headquarters level

The total estimated cost is US\$ 7.44 million.

For the provision of technical assistance (consultancies, including short-term contracts, Agreements for Performance of Work, scientific and technical advisory groups; travel; and training): US\$ 750 000.

Staff costs (P5 staff for two years, P4 staff for two years and G4 staff for two years): US\$ 1.65 million. This figure is based on the estimated cumulative time to be spent by a number of staff at different levels for this particular activity.

The estimated total cost of strengthening the evidence base for health emergency and disaster risk-management, including operational research and economic assessments: US\$ 2.79 million.

The estimated total cost of supporting national assessments of risks and capacities for health emergency and disaster risk-management, as a basis for catalysing action and strengthening national health emergency and disaster risk-management capacities: US\$ 2.25 million.

At regional level

The total estimated cost: US\$ 4.5 million (US\$ 750 000 per regional office).

At country level

The estimated minimum cost of provision of technical support by the Secretariat through the country offices to Member States implementing the resolution: US\$ 250 000 per country.

(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).

At headquarters level

For the provision of technical assistance (including consultancies involving short-term contracts and Agreements for Performance of Work, travel, training, scientific and technical advisory groups): US\$ 250 000.

For the strengthening of collaboration with relevant entities (including public, private and non-governmental bodies and academia) to support country and community health emergency and disaster risk-management, the estimated staff cost is: US\$ 550 000 (P5 staff, US\$ 250 000; P4 staff, US\$ 200 000; and G4 staff, US\$ 100 000). This figure is based on the estimated cumulative time to be spent by a number of staff at different levels for this particular activity for a period of one year.

The estimated total cost of strengthening the evidence base for health emergency and disaster risk-management, including operational research and economic assessments: US\$ 930 000.

The estimated total cost of supporting national assessments of risks and capacities for health emergency and disaster risk-management, as a basis for catalysing action and strengthening national health emergency and disaster risk-management capacities: US\$ 750 000.

At regional level

The estimated total cost: US\$ 1.5 million (US\$ 250 000 per regional office).

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| <p>At country level</p> <p>The estimated minimum cost of provision by the Secretariat of technical support for implementation through country offices: US\$ 50 000 per country.</p> <p>(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?</p> <p>Yes, except at country level.</p> |
| <p>4. Financial implications</p> <p>How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?</p> <p>Through fund-raising and voluntary contributions.</p> |
| <p>5. Administrative implications</p> <p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).</p> <p>Implementation will take place mainly in the country offices. Regional offices will provide support for training and capacity building and headquarters will be responsible for interagency coordination, overall planning and development of the evidence-based norms and guidelines necessary to develop and strengthen this area of work. The WHO Mediterranean Centre for Vulnerability Reduction in Tunis will provide technical assistance to all levels in areas of its expertise.</p> <p>(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.</p> <p>At the headquarters level, staffing is sufficient for the development component of this area and the staff cost is budgeted. At the regional and national levels, there is a need for additional expertise that could be recruited on a temporary basis (short-term contracts and Agreements for Performance of Work).</p> <p>(c) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile).</p> <p>Not applicable.</p> <p>(d) Time frames (indicate broad time frames for implementation of activities).</p> <p>These activities are planned for the bienniums 2010–2011 and 2012–2013.</p> |

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| 1. Resolution EB128.R11 Strengthening nursing and midwifery | |
| 2. Linkage to programme budget | |
| <p>Strategic objective:</p> <p>10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.</p> | <p>Organization-wide expected result:</p> <p>10.8 Health-workforce information and knowledge base strengthened, and country capacities for policy analysis, planning, implementation, information-sharing and research built up.</p> <p>10.9 Technical support provided to Member States, with a focus on those facing severe health-workforce difficulties in order to improve the production, distribution, skill mix and retention of the health workforce.</p> |

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

WHO's activities in support of health workforce strengthening have links with strategic objective 10, specifically the two Organization-wide expected results mentioned above. Countries facing severe nursing and midwifery difficulties will be supported through WHO's activities to adopt relevant technical frameworks, tools and guidelines for strengthening nursing and midwifery practice.

3. Budgetary implications

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

A total of US\$ 4 million, covering the four-year period 2011–2014, will be required for the implementation of activities at all levels of WHO and the provision of support to Member States.

- (b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000, including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).**

For the biennium, a total of US\$ 2 million will be incurred (US\$ 500 000 at headquarters level and US\$ 1.5 million at regional level).

- (c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?**

A total of US\$ 400 000 is included for headquarters and the regions.

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

The cost will be met through a combination of voluntary and assessed contributions from Member States, together with contributions from international partners.

5. Administrative implications

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

All levels of the Organization will be involved; however, implementation will particularly concern countries facing major challenges as a result of critical health workforce shortages.

- (b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.**

No. Additional staff will be required at headquarters and in the regions.

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

Exact requirements will depend on the intensity of activities. Every effort will be made to make full use of secondments and the deployment of interns in addition to employing short-term staff.

- (d) Time frames (indicate broad time frames for implementation of activities).**

The resolution requests the Director-General to report on progress to the Health Assembly in 2012 and 2014. Implementation of activities will be built into biennial workplans for 2010–2011, 2012–2013 and 2014–2015, as appropriate.

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| <p>1. Resolution EB128.R12 Strengthening national policy dialogue to build more robust health policies, strategies and plans</p> | |
| <p>2. Linkage to programme budget</p> | |
| <p>Strategic objective:</p> <p>10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.</p> | <p>Organization-wide expected result:</p> <p>10.1 Management and organization of integrated, population-based health-service delivery through public and nonpublic providers and networks improved, reflecting the primary health care strategy, scaling up coverage, equity, quality and safety of personal and population-based health services, and enhancing health outcomes.</p> <p>10.2 National capacities for governance and leadership improved through evidence-based policy dialogue, institutional capacity-building for policy analysis and development, strategy-based health-system performance assessment, greater transparency and accountability for performance, and more effective intersectoral collaboration.</p> <p>10.3 Coordination of the various mechanisms (including donor assistance) that provide support to Member States in their efforts to achieve national targets for health-system development and global health goals improved.</p> |
| <p align="center">(Briefly indicate the linkage with expected results, indicators, targets, baseline)</p> <p>This resolution is linked to resolution WHA62.12 on primary health care, including health system strengthening.</p> | |
| <p>3. Budgetary implications</p> <p>(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).</p> <p>US\$ 50 million over a period of six years.</p> <p>(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).</p> <p>US\$ 8 million at all levels of the Organization.</p> <p>(c) Is the estimated cost noted in (b) included within the existing approved Programme budget for the biennium 2010-2011?</p> <p>Yes.</p> | |
| <p>4. Financial implications</p> <p>How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?</p> <p>Costs will be met through income from voluntary contributions from Member States and contributions from international partners.</p> | |

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

All levels of the Organization will be involved.

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.

No.

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

Exact requirements will depend on the intensity of activities. Every effort will be made to make full use of secondments in addition to employing short-term staff.

(d) Time frames (indicate broad time frames for implementation of activities).

The Secretariat is drawing up implementation plans.

1. Resolution EB128.R13 Malaria**2. Linkage to programme budget**

Strategic objective:

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

Organization-wide expected result:

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

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

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

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

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

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

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

The resolution builds on the United Nations General Assembly resolution 55/284, which proclaimed the period 2001–2010 the Decade to Roll Back Malaria, particularly in Africa; and on resolutions WHA58.2 and WHA60.18, the latter of which resolved that World Malaria Day should be commemorated globally and annually. The resolution is taking forward the call by the United Nations Secretary-General for universal coverage with antimalarial interventions; it also provides the framework for achieving the array of malaria control-related expected results, targets and baseline figures for strategic objective 2 as outlined in the Medium-term strategic plan 2008–2013. Furthermore, these results, targets and baseline figures are aligned with the expected results and indicators included in the Roll Back Malaria Global Malaria Action Plan for the period 2008–2015.

3. Budgetary implications

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

The life-cycle of the resolution is 2011–2015. The estimated cost of the Secretariat's responsibility for coordinating full-scale implementation after 2012 is US\$ 500 000.

- (b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).**

A total of US\$ 250 000 is needed to enable the secretariat of the Global Malaria Programme to start working on the provision of support to implementation.

- (c) Is the estimated cost noted in (b) included within the existing approved Programme budget for the biennium 2010–2011?**

Eighty per cent of the estimated costs will be covered by the approved Programme budget.

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| <p>4. Financial implications</p> <p>How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?</p> <p>Extrabudgetary sources of funding will be mobilized.</p> |
| <p>5. Administrative implications</p> <p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).</p> <p>Malaria poses a major threat in all regions, and implementing the resolution will require action at headquarters, regional offices and in the country offices of the countries in which malaria is endemic.</p> <p>(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.</p> <p>No additional positions will need to be established to support implementation.</p> <p>(c) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile).</p> <p>See point (b) above.</p> <p>(d) Time frames (indicate broad time frames for implementation of activities).</p> <p>The time frame of the resolution is five years.</p> |

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| 1. Resolution EB128.R14 Election of the Director-General of the World Health Organization | |
| 2. Linkage to programme budget | |
| Strategic objective: | Organization-wide expected result: |
| 12. To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work. | 12.1 Effective leadership and direction of the Organization exercised through enhancement of governance, and the coherence, accountability and synergy of WHO's work. |
| (Briefly indicate the linkage with expected results, indicators, targets, baseline) | |
| Work in support of governance and leadership has implications for all the expected results and indicators for this strategic objective, and for the achievement of all the strategic objectives in the Programme budget. | |
| 3. Budgetary implications | |
| (a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities). | |
| The Secretariat will need to organize two intergovernmental meetings, each covering a period of five days. The estimated total cost is US\$ 2 million. This figure includes reimbursement of travel costs for one representative from each least developed country, in accordance with resolution WHA50.1. | |

- (b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).**

US\$ 1.4 million.

- (c) Is the estimated cost noted in (b) included within the existing approved Programme budget for the biennium 2010–2011?**

No.

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

Extrabudgetary sources of funding will be mobilized.

5. Administrative implications

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

WHO headquarters.

- (b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.**

Not entirely. No additional costs are anticipated for the Office of the Governing Bodies, the Office of the Legal Counsel or the Department of Logistics Support Services. However, existing staff will need to be redeployed, and other activities will have to be deferred as a consequence. Additional staff will be required for the intergovernmental meetings (see below).

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

Conference staff will need to be recruited before, during and after the meetings. The figures mentioned above include the cost of recruitment.

- (d) Time frames (indicate broad time frames for implementation of activities).**

The resolution establishes a time-bound and results-oriented working group of Member States on the process and methods of the election of the Director-General. The working group will submit an interim progress report to the Sixty-fourth World Health Assembly; a final report will be submitted, through the Executive Board, to the Sixty-fifth World Health Assembly.

Implementation therefore covers the 16-month period until the Sixty-fifth World Health Assembly.

1. Resolution EB128.R15 Child injury prevention

2. Linkage to programme budget

Strategic objective:

3. To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment.

Organization-wide expected result:

3.1 Advocacy and support provided to increase political, financial and technical commitment in Member States in order to tackle chronic noncommunicable diseases, mental and behavioural disorders, violence, injuries and disabilities, together with visual impairment, including blindness.

3.2 Guidance and support provided to Member States for the development and implementation of policies, strategies and regulations in respect of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities, together with visual impairment, including blindness.

3.3 Improvements made in Member States' capacity to collect, analyse, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities, together with visual impairment, including blindness.

3.5 Guidance and support provided to Member States for the preparation and implementation of multisectoral, population-wide programmes to promote mental health, and to prevent mental and behavioural disorders, violence and injuries, together with hearing and visual impairment, including blindness.

3.6 Guidance and support provided to Member States to improve the ability of their health and social systems to prevent and manage chronic noncommunicable diseases, mental and behavioural disorders, violence, injuries and disabilities, together with visual impairment, including blindness.

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

The resolution provides a framework that will contribute to the achievement of the expected results in terms of the planned indicators, targets and baseline.

3. Budgetary implications

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

It is estimated that this resolution will have a life-cycle of 10 years (2011–2021). The estimated cost of the Secretariat's activities in support of implementation is US\$ 10 million.

- (b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).**

If the resolution is adopted by the Health Assembly in May 2011, the estimated cost during the biennium 2010–2011 of the relevant Secretariat activities would be US\$ 500 000. It would be incurred at all levels of the Organization.

- (c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?**

Yes.

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| <p>4. Financial implications</p> <p>How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?</p> <p>Existing extrabudgetary sources are insufficient to support this cost fully. The Secretariat will investigate additional sources of funding.</p> |
| <p>5. Administrative implications</p> <p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).</p> <p>All WHO regions and countries.</p> <p>(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.</p> <p>No.</p> <p>(c) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile).</p> <p>At headquarters, an additional staff member would be required at P4 level to coordinate follow-up activities.</p> <p>(d) Time frames (indicate broad time frames for implementation of activities).</p> <p>2011–2021.</p> |

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| 1. Resolution EB128.R16 Relations with nongovernmental organizations | |
| 2. Linkage to programme budget | |
| <p>Strategic objective:</p> <p><i>Lifting The Burden</i></p> <p>3. To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment.</p> | <p>Organization-wide expected result:</p> <p>3.3 Improvements made in Member States' capacity to collect, analyse, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities together with visual impairment, including blindness.</p> <p>3.4 Improved evidence compiled by WHO on the cost-effectiveness of interventions to tackle chronic noncommunicable diseases, mental and neurological and substance-use disorders, violence, injuries and disabilities together with visual impairment, including blindness.</p> |

*Stichting Global Initiative on Psychiatry –
an International Foundation for the
Promotion of Humane, Ethical, and
Effective Mental Health Care throughout
the World¹*

3. To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment.

6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex.

The Cochrane Collaboration

4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals.

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

9. To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development.

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

3.1 Advocacy and support provided to increase political, financial and technical commitment in Member States in order to tackle chronic noncommunicable diseases, mental and behavioural disorders, violence, injuries and disabilities together with visual impairment, including blindness.

3.2 Guidance and support provided to Member States for the development and implementation of policies, strategies and regulations in respect of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities together with visual impairment, including blindness.

6.6 Evidence-based and ethical policies, strategies, interventions, recommendations, standards and guidelines developed and technical support provided to Member States to promote safer sex and strengthen institutions in order to tackle and manage the social and individual consequences of unsafe sex.

4.2 National research capacity strengthened as necessary and new evidence, products, technologies, interventions and delivery approaches of global and/or national relevance available to improve maternal, newborn, child and adolescent health, to promote active and healthy ageing, and to improve sexual and reproductive health.

5.1 Norms and standards developed, capacity built and technical support provided to Member States for the development and strengthening of national emergency preparedness plans and programmes.

9.2 Norms, including references, requirements, research priorities, guidelines, training manuals and standards, produced and disseminated to Member States in order to increase their capacity to assess and respond to all forms of malnutrition, and zoonotic and non-zoonotic foodborne diseases, and to promote healthy dietary practices.

10.2 National capacities for governance and leadership improved through evidence-based policy dialogue, institutional capacity-building for policy analysis and development, strategy-based health system performance assessment, greater transparency and

¹ Known as the Global Initiative on Psychiatry.

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

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

accountability for performance, and more effective intersectoral collaboration.

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.

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

12.4 Essential multilingual health knowledge and advocacy material made accessible to Member States, health partners and other stakeholders through the effective exchange and sharing of knowledge.

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

Lifting The Burden – collaboration with WHO is linked to indicators 3.3.3 and 3.4.1. Activities are expected to contribute to the achievement of, respectively, the targets for 2013 of 120 low- and middle-income Member States with basic mental health indicators annually reported, and evidence-based guidance on the effectiveness of interventions for the management of selected mental, behavioural or neurological disorders (including those due to use of psychoactive substances) published and disseminated for 16 interventions.¹

Global Initiative on Psychiatry – collaboration is linked to indicators 3.1.3 and 3.2.2. Activities are expected to contribute to the achievement of, respectively, the targets for 2013 of 110 Member States having a mental health budget of more than 1% of the total health budget and 64 Member States that have initiated the process of developing a mental health policy or law. Collaboration is also linked to indicator 6.6.1 and is expected to contribute to the achievement of the target for 2013 of 12 Member States generating evidence on the determinants and/or consequences of unsafe sex.¹

The Cochrane Collaboration – collaboration with different technical areas of WHO is linked as set out below.

Reproductive health and research

Activities are linked to strategic objective 4. The contribution of The Cochrane Collaboration will be made through its review groups on pregnancy and childbirth and on fertility regulation, which will facilitate the development and maintenance of systematic reviews that will support WHO normative products.

¹ See document EB128/24.

Nutrition for health and development

Activities are linked to strategic objectives 4 and 9. The contribution of The Cochrane Collaboration will be made through the updating of systematic reviews on nutrition interventions in support of WHO's normative work. Activities will involve the Collaboration's review groups (particularly those on pregnancy and childbirth; public health; developmental, psychosocial and learning problems; child health; and metabolic and endocrine disorders) working through the organization's editorial office.

Health action in crises

Activities are linked to strategic objective 5 and concern the development of the evidence base to support decisions and actions to reduce the health consequences of natural disasters and other large-scale emergencies. The Cochrane Collaboration will contribute to expected results for this strategic objective through work to support: the development of the research agenda; the establishment of a research advisory group; the publication of selected research for (i) capacity development and (ii) emergency response on the web sites of The Cochrane Collaboration's Evidence Aid project and WHO before and after disasters; the development of research protocols and methods for emergency-related work; and the preparation of systematic reviews on priority areas related to emergencies.

Research policy and cooperation, essential medicines and pharmaceutical policies, and knowledge management and sharing

The activities are linked to strategic objectives 10, 11 and 12. The contribution of The Cochrane Collaboration will specifically concern expected results 4.2, 10.2, 10.5, 11.2 and 12.4, with work involving the provision of better evidence for health decision-making through the use of: systematic, methodologically sound and transparent methods; capacity building and effective communication and sharing of the results; and improved access to, and quality of, medical products and technologies. The agreed collaboration is expected to result in enhanced exchange.

3. Budgetary implications

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

All the nongovernmental organizations – none.

- (b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000, including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).**

All the nongovernmental organizations – none.

- (c) Is the estimated cost noted in (b) included within the existing approved Programme budget for the biennium 2010–2011?**

All the nongovernmental organizations – not applicable.

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

All the nongovernmental organizations – not applicable.

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

Lifting The Burden – WHO headquarters and regional offices.

Global Initiative on Psychiatry – WHO headquarters and regional offices.

The Cochrane Collaboration

Reproductive health and research – WHO headquarters

Nutrition for health and development – WHO headquarters

Health action in crises – WHO headquarters, all regional offices, and at the WHO Mediterranean Centre for Health Risk Reduction, Tunis.

Research, policy and cooperation, essential medicines and pharmaceutical policies, knowledge management and sharing – WHO headquarters and all regional offices.

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.

All the nongovernmental organizations – yes.

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

All the nongovernmental organizations – none.

(d) Time frames (indicate broad time frames for implementation of activities).

All the nongovernmental organizations – three years for implementation, after which the Executive Board will review the relations, in accordance with the Principles governing relations between the World Health Organization and nongovernmental organizations.¹

¹ *Basic documents*, 47th edition, Geneva, World Health Organization, 2009.