



WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD

130TH SESSION

GENEVA, 16–23 January 2012

**RESOLUTIONS AND DECISIONS
ANNEXES**

GENEVA
2012

PREFACE

The 130th session of the Executive Board was held at WHO headquarters, Geneva, from 16 to 23 January 2012. 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 EB130/2012/REC/2.

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¹ See page ix.

² See Annex 1.

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EB130/27	Report of the International Civil Service Commission
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¹ See Annex 6.

² See Annex 4.

³ See Annex 5.

EB130/34	Report on meetings of expert committees and study groups
EB130/34 Add.1	Expert advisory panels and committees and their membership
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Information documents

EB130/INF.DOC./1	Nomination of the Director-General: nomination for the post
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Diverse documents

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RESOLUTIONS

EB130.R1 Appointment of the Regional Director for the Eastern Mediterranean

The Executive Board,

Considering the provisions of Article 52 of the Constitution of the World Health Organization;

Considering the nomination made by the Regional Committee for the Eastern Mediterranean at its fifty-eighth session,¹

1. APPOINTS Dr Ala Din Alwan as Regional Director for the Eastern Mediterranean as from 1 February 2012; and
2. AUTHORIZES the Director-General to issue to Dr Ala Din Alwan a contract for a period of five years from 1 February 2012 subject to the provisions of the Staff Regulations and Staff Rules; and
3. AUTHORIZES the Director-General to amend the conditions of employment of Dr Ala Din Alwan as follows: “You will not participate in the United Nations Joint Staff Pension Fund but will instead receive as a monthly supplement the contribution that the Organization would have paid each month to the Pension Fund had you been a participant.”

(Third meeting, 17 January 2012)

EB130.R2 Appreciation of the outgoing Regional Director for the Eastern Mediterranean

The Executive Board,

Desiring to express its appreciation to Dr Hussein A. Gezairy on the occasion of 30 years of devoted service to the World Health Organization as Regional Director for the Eastern Mediterranean;

Mindful of his lifelong, professional devotion to the cause of international health,

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

(Third meeting, 17 January 2012)

¹ Resolution EM/RC58/R.6.

EB130.R3 Monitoring the achievement of the health-related Millennium Development Goals: implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health

The Executive Board,

Having considered the report on monitoring the achievement of the health-related Millennium Development Goals: implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health,¹

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

The Sixty-fifth World Health Assembly,

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

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

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

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

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

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

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

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

¹ Document EB130/14.

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

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

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

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

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

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

3. REQUESTS the Director-General:

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

(Fourth meeting, 17 January 2012)

EB130.R4 Nomination for the post of the Director-General

The Executive Board,

1. NOMINATES Dr Margaret Chan for the post of Director-General of the World Health Organization, in accordance with Article 31 of the Constitution of the World Health Organization;

2. SUBMITS this nomination to the Sixty-fifth World Health Assembly.

(Fifth meeting, 18 January 2012)

EB130.R5 Draft contract of the Director-General

The Executive Board,

In accordance with the requirements of Rule 107 of the Rules of Procedure of the World Health Assembly,

1. SUBMITS to the Sixty-fifth World Health Assembly the draft contract establishing the terms and conditions of appointment of the Director-General;¹
2. RECOMMENDS to the Sixty-fifth World Health Assembly the adoption of the following resolution:

The Sixty-fifth World Health Assembly,

I

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

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

II

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

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

(Fifth meeting, 18 January 2012)

EB130.R6 Strengthening noncommunicable disease policies to promote active ageing

The Executive Board,

Having considered the reports on prevention and control of noncommunicable diseases and the need for integrated management of prevention and control of noncommunicable diseases in order to promote active ageing,²

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

¹ See Annex 1.

² Documents EB130/6, EB130/7 and EB130/8.

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

The Sixty-fifth World Health Assembly,

Having considered the report on the outcomes of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases and the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control and the report on the implementation of the global strategy for the prevention and control of noncommunicable diseases and the action plan;

Recalling the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases,¹ the Moscow Declaration adopted at the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control (Moscow, 28 and 29 April 2011),² and the resolution WHA64.11 on preparations for the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, following on the Moscow Conference;

Recalling the Millennium Development Goals (MDGs) Follow-up Meeting (Tokyo, 2 and 3 June 2011), with the participation of more than 110 countries, about 20 United Nations or regional organizations and civil society organizations, at which it was agreed that noncommunicable diseases are emerging global challenges not only for the post-2015 era, but which also threaten the achievement of the internationally agreed development goals including the Millennium Development Goals;

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

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

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

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

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

¹ See Annex 2.

² See document WHA64/2011/REC/1, Annex 3.

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

Recalling further United Nations General Assembly resolution 57/167, which endorsed the Political Declaration and the Madrid International Plan of Action on Ageing, as well as other relevant resolutions on ageing;

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

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

Acknowledging the Rio Political Declaration on Social Determinants of Health,¹ which expressed the determination to achieve social and health equity through actions on the social determinants of health and well-being with a comprehensive intersectoral approach;

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

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

1. URGES Member States:²

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

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

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

¹ See Annex 3.

² And where applicable, regional economic integration organizations.

- (4) to promote, as appropriate, conditions that enable individuals, carers, families and communities to encourage healthy ageing, including care for, provision of support to and protection of older persons, taking into account physical and psychological aspects of ageing, and to focus on intergenerational approaches;
- (5) to encourage the active participation of older people in society and in their local community;
- (6) to strengthen cooperation and partnership among Member States¹ at all levels of government, among stakeholders, academia, research foundations, the private sector and civil society, in order to implement plans and programmes effectively;
- (7) to highlight the importance of a primary health care approach in national health-care planning, in close collaboration with social services, and of enabling integration of health promotion and prevention and control of noncommunicable diseases into ageing policies;
- (8) to encourage making available measures and resources to provide health promotion, health care and social protection for healthy and active ageing, paying special attention to access to affordable medicines and the importance of training, education and capacity-building of the health workforce in collaboration with WHO and partners;
- (9) to further strengthen monitoring and evaluation systems for generating and analysing data on noncommunicable diseases, disaggregated by age, sex and socioeconomic status, with the aim of developing equitable evidence-based policies and planning for older persons;

2. REQUESTS the Director-General:

- (1) to provide support to Member States in promoting and facilitating further implementation of commitments made at relevant United Nations conferences and summits on noncommunicable diseases and ageing;
- (2) to provide support to Member States in placing emphasis on health promotion and disease prevention throughout the life-course starting at the earliest stage possible, including multisectoral approaches to healthy ageing, integrated care for older persons and support for providers of formal and informal welfare services;
- (3) to support Member States in developing policies and programmes for access to affordable medicines for the ageing;
- (4) to provide further support to Member States in raising awareness of healthy and active ageing and of the positive aspects of ageing by means that include ageing-specific policies and the mainstreaming of ageing in their national strategies;
- (5) to support the advancement of country-level systems for monitoring noncommunicable diseases, as appropriate, and continue to develop a comprehensive global monitoring system for prevention and control of noncommunicable diseases to track trends and monitor progress in implementation of the Political Declaration;

¹ And where applicable, regional economic integration organizations.

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

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

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

(Eighth meeting, 19 January 2012)

EB130.R7 Prevention and control of noncommunicable diseases: follow-up to the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases¹

The Executive Board,

Having considered the reports on prevention and control of noncommunicable diseases: outcomes of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases and the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control² and on implementation of the global strategy for the prevention and control of noncommunicable diseases and the action plan;³

Recalling the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases,⁴ the Moscow Declaration adopted at the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control,⁵ and resolution WHA64.11 of the World Health Assembly;

Acknowledging the Rio Political Declaration on Social Determinants of Health, adopted by the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 19–21 October 2011),⁶ which expressed the determination to achieve social and health equity through action on the social determinants of health and well-being by a comprehensive intersectoral approach;

Reaffirming the leading role of WHO as the primary specialized agency for health and its leadership and coordination role in promoting and monitoring global action against noncommunicable diseases (as described in paragraphs 13 and 46 of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases);

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

² Document EB130/6.

³ Document EB130/7.

⁴ United Nations General Assembly resolution 66/2, see also Annex 2.

⁵ See document WHA64/2011/REC/1, Annex 3.

⁶ See Annex 3.

Reaffirming also the central role of WHO recognized in the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases for monitoring and evaluation and guiding multisectoral engagement;

Recognizing in particular the call made in the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases (paragraphs 61 and 62) to develop a comprehensive global monitoring framework, including a set of indicators, capable of application across regional and country settings, and to develop recommendations for a set of voluntary global targets for the prevention and control of noncommunicable diseases, and to complete this work before the end of 2012;

Recalling resolution WHA61.14, which endorsed the 2008–2013 action plan for the global strategy for the prevention and control of noncommunicable diseases, and recognizing the progress made to date under the action plan;

Reiterating the concern that the rapidly growing magnitude of noncommunicable diseases affects people of all ages, gender, race and income levels, and further that poor populations and those living in vulnerable situations, in particular in developing countries, bear a disproportionate burden and that noncommunicable diseases can affect women and men differently;

Noting with concern the growing double burden of communicable and noncommunicable diseases in Africa, and the need for integrated approaches to their prevention and control;

Noting with concern that an estimated 36 million of the 57 million deaths in the world in 2008 were due to noncommunicable diseases such as cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, and that nearly 80% of those deaths occurred in developing countries,

1. URGES Member States:¹

(1) to implement the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases;

(2) to draw upon, based on national contexts, the policies, strategies, programmes and interventions, and tools recommended by WHO, in accordance with paragraph 45 of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, in order to promote, establish or support and strengthen, by 2013, as appropriate, multisectoral national policies and plans for the prevention and control of noncommunicable diseases;

(3) to strengthen their commitment to implementing noncommunicable disease programmes in accordance with national priorities, including increased efforts in prevention, diagnostics and treatment and to take steps to accelerate health-related donor harmonization and adherence to aid effectiveness principles, bearing in mind the growing concern about the double burden of communicable and noncommunicable disease in many countries and the need for an integrated response;

(4) to participate fully in the WHO-led process of developing a comprehensive global monitoring framework, including a set of indicators, capable of application across regional and country settings, and of developing recommendations for a set of voluntary global targets for the

¹ And, where applicable, regional economic integration organizations.

prevention and control of noncommunicable diseases before the end of 2012, and to consider incorporating elements of this work into national planning exercises at the earliest opportunity in accordance with national priorities;

2. REQUESTS the Director-General:

(1) to continue in an inclusive and transparent manner, the process under way to develop, in accordance with paragraphs 61 and 62 of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, a comprehensive global monitoring framework, including a set of indicators, capable of application across regional and country settings, and to develop recommendations for a set of voluntary global targets for the prevention and control of noncommunicable diseases, and to complete this work by the end of 2012, building on the outcomes of the consultation with Member States¹ and organizations in the United Nations system (Geneva, 9 January 2012), as follows:

(a) by the end of January 2012 the Secretariat will provide Member States with additional information requested at that consultation;

(b) by the end of February 2012, a web-based consultation on a draft framework and indicators and targets will close, following which WHO will revise the draft documents for step (c);

(c) before the Sixty-fifth World Health Assembly, a second Member State¹ consultation on the framework and indicators and targets will be held;

(d) as part of this process, the Secretariat should also hold consultations with all interested stakeholders;

(e) submit a substantive progress report on the development of a framework, including a set of indicators and targets, to the Sixty-fifth World Health Assembly for consideration;

(f) regional consultations will provide further input into the framework/target process as part of their broader discussions on implementation of the Political Declaration;

(g) complete the work on the global monitoring framework, including a set of indicators and targets, based on a Member State¹ consultation held before the end of 2012;

(h) report on the recommendations relating to paragraphs 61 and 62 of the Political Declaration, through the Executive Board at its 132nd session, to the Sixty-sixth World Health Assembly;

(2) to develop, in a consultative manner, WHO's input, called for in paragraph 64 of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, concerning options for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases

¹And, where applicable, regional economic integration organizations.

through effective and transparent partnership, while safeguarding public health from any potential conflict of interest, and submit it to the Secretary-General by the end of 2012;

(3) to submit a progress report and a timeline for WHO's input on options for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases through effective partnership to the Sixty-fifth World Health Assembly;

(4) to develop, in a consultative manner, a WHO action plan for the prevention and control of noncommunicable diseases for 2013–2020, building on lessons learnt from the 2008–2013 action plan and taking into account the outcomes of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, the Moscow Declaration on Healthy Lifestyles and Noncommunicable Disease Control, the Rio Declaration on Social Determinants of Health, building on and being consistent with existing WHO strategies and tools on tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity;

(5) to build on work from the 2008–2013 action plan, which, inter alia, called for WHO to provide support to countries in enhancing access to essential medicines, to facilitate engagement by governments and, as appropriate, civil society and the private sector with appropriate safeguards against conflict of interest, in accordance with relevant paragraphs of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, for improved access to medicines;

(6) to submit to the Sixty-sixth World Health Assembly, through the Executive Board, a WHO action plan for the prevention and control of noncommunicable diseases for 2013–2020 for consideration and possible adoption.

(Ninth meeting, 20 January 2012)

EB130.R8 The global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level

The Executive Board,

Having considered the report on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level,¹

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

The Sixty-fifth World Health Assembly,

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

¹ Document EB130/9.

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

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

Recalling further United Nations General Assembly resolution 65/95, which recognized that mental health problems are of major importance to all societies and are significant contributors to the burden of disease and the loss of quality of life, and have huge economic and social costs, and which also welcomed the WHO report on mental health and development¹ that highlighted the lack of appropriate attention to mental health and made the case for governments and development actors to reach out to people with mental disorders in the design of strategies and programmes that include those people in education, employment, health, social protection and poverty reduction policies;

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

Recognizing that mental disorders can lead to disabilities, as reflected in the United Nations Convention on the Rights of Persons with Disabilities, which also notes that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others, and that the *World report on disability*² charts the steps that are required to improve the participation and inclusion of people with disabilities, including persons with mental disabilities;

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

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

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

Recognizing further that the treatment gap for mental disorders is large all over the world, that between 76% and 85% of people with severe mental disorders in low- and middle-income

¹ *Mental health and development: targeting people with mental health conditions as a vulnerable group*. Geneva, World Health Organization, 2010.

² World Health Organization, The World Bank. *World report on disability*. Geneva, World Health Organization, 2011.

countries receive no treatment for their mental health conditions, and that the corresponding figures for high-income countries are also high – between 35% and 50%;

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

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

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

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

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

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

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

1. URGES Member States:¹

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

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

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

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

¹ And, where applicable, regional economic integration organizations.

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

2. REQUESTS the Director-General:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Tenth meeting, 20 January 2012)

EB130.R9 Elimination of schistosomiasis

The Executive Board,

Having considered the report on the elimination of schistosomiasis,¹

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

The Sixty-fifth World Health Assembly,

Having considered the report on the elimination of schistosomiasis;

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

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

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

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

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

¹ Document EB130/20.

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

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

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

1. CALLS ON all countries endemic for schistosomiasis:
 - (1) to attach importance to prevention and control of schistosomiasis, analyse and develop applicable plans with progressive targets, intensify control interventions and strengthen surveillance;
 - (2) to take full advantage of non-health programmes to improve the environment, in order to cut the transmission of schistosomiasis and accelerate the elimination of the intermediate host;
 - (3) to ensure the provision of essential medicines;
2. URGES Member States, the Secretariat and partners to provide support to countries endemic for schistosomiasis to expand control programmes;
3. REQUESTS the Director-General:
 - (1) to encourage Member States and the international community to make available the necessary and sufficient means and resources, particularly medicines, and water, sanitation, and hygiene interventions, to intensify control programmes in most disease-endemic countries and initiate elimination campaigns, where appropriate;
 - (2) to prepare guidance for Member States in order to determine when to initiate elimination campaigns, along with methods for implementing programmes and documenting success;
 - (3) to assess, on request, the interruption of transmission in the appropriate Member States, to analyse the global status of schistosomiasis prevention and control, the epidemic model, and key challenges, so as to provide targeted recommendations and guidance;
 - (4) to report every three years through the Executive Board, to the World Health Assembly, on progress in implementing this resolution.

(Tenth meeting, 20 January 2012)

EB130.R10 Polio myelitis: intensification of the global eradication initiative

The Executive Board,

Having considered the report on poliomyelitis: intensification of the global eradication initiative,¹

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

The Sixty-fifth World Health Assembly,

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

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

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

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

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

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

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

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

¹ Document EB130/19.

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

1. DECLARES the completion of poliovirus eradication a programmatic emergency for global public health, requiring the full implementation of current and new eradication strategies, the institution of strong national oversight and accountability mechanisms for all areas infected with poliovirus, and the application of appropriate vaccination recommendations for all travellers to and from areas infected with poliovirus;¹
2. URGES Member States with poliovirus transmission to declare such transmission to be a “national public health emergency” making poliovirus eradication a national priority programme, requiring the development and full implementation of emergency action plans, to be updated every six months, until such time as poliovirus transmission has been interrupted;
3. URGES all Member States:
 - (1) to eliminate the unimmunized areas and to maintain very high population immunity against polioviruses through routine immunization programmes and, where necessary, supplementary immunization activities;
 - (2) to maintain vigilance for poliovirus importations, and the emergence of circulating vaccine-derived polioviruses, by achieving and sustaining certification-standard surveillance and regular risk assessment for polioviruses;
 - (3) to make available urgently the financial resources required for the full and continued implementation, to the end of 2013, of the necessary strategic approaches to interrupt wild poliovirus transmission globally, and to initiate planning for the financing to the end of 2018 of the polio endgame strategy;
 - (4) to engage in multilateral and bilateral cooperation, including exchanging epidemic information, laboratory monitoring data, and carrying out supplementary immunization activities simultaneously as appropriate;
4. REQUESTS the Director-General:
 - (1) to plan for the renewed implementation through 2013 of the approaches for eradicating wild polioviruses outlined in the Global Polio Eradication Initiative Strategic Plan 2010–2012 and any new tactics that are deemed necessary to complete eradication, including the enhancement of the existing global polio eradication initiative within the Organization;
 - (2) to strengthen accountability and monitoring mechanisms to ensure optimal implementation of eradication strategies at all levels;
 - (3) to undertake the development, scientific vetting, and rapid finalization of a comprehensive polio eradication and endgame strategy that exploits new developments in poliovirus diagnostics and inactivated poliovirus vaccines; informs Member States of the potential timing of a switch from trivalent to bivalent oral poliovirus vaccine for all routine immunization programmes; and includes budget scenarios to the end of 2018 that include risk management;

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

- (4) to coordinate with all relevant partners to promote the research, production and supply of vaccines, to enhance their affordability, effectiveness and accessibility;
- (5) to continue mobilizing and deploying the necessary financial and human resources for the strategic approaches required through 2013 for wild poliovirus eradication, and for the eventual implementation of a polio endgame strategy to the end of 2018;
- (6) to report to the Sixty-sixth World Health Assembly and the subsequent two Health Assemblies, through the Executive Board, on progress in implementing this resolution.

(Eleventh meeting, 21 January 2012)

EB130.R11 Outcome of the World Conference on Social Determinants of Health

The Executive Board,

Having considered the report on the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, October 2011),¹

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

The Sixty-fifth World Health Assembly,

Having considered the report on the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 19–21 October 2011);

Reiterating the determination to take action on social determinants of health as collectively agreed by the World Health Assembly and reflected in resolution WHA62.14 on reducing health inequities through action on the social determinants of health, which notes the three overarching recommendations of the Commission on Social Determinants of Health: to improve daily living conditions; to tackle the inequitable distribution of power, money and resources; and to measure and understand the problem and assess the impact of action;

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

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

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

¹ Document EB130/15.

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

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

Reaffirming the political will to make health equity a national, regional and global goal and to address current challenges – such as eradicating hunger and poverty; ensuring food and nutritional security, access to affordable, safe, efficacious and quality medicines as well as to safe drinking-water and sanitation, employment and decent work and social protection; protecting environments and delivering equitable economic growth through resolute action on social determinants of health across all sectors and at all levels;

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

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

2. URGES Member States:²

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

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

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

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

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

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

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

¹ See Annex 3.

² And, where applicable, regional economic integration organizations.

provision of financial and technical support to countries and regions, in particular developing countries;

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

(3) facilitating access to financial resources;

4. URGES those developed countries that have pledged to achieve the target of 0.7% of gross national product for official development assistance by 2015, and those developed countries that have not yet done so, to make additional concrete efforts to fulfil their commitments in this regard, and also urges developing countries to build on progress achieved in ensuring that official development assistance is used effectively to help achieve development goals and targets;

5. REQUESTS the Director-General:

(1) to duly consider social determinants of health in the assessment of global needs for health, including in the WHO reform process and WHO's future work;

(2) to provide support to Member States in implementing the Rio Political Declaration on Social Determinants of Health through approaches such as "health-in-all policies" in order to address social determinants of health;

(3) to work closely with other organizations in the United Nations system on advocacy, research, capacity-building and direct technical support to Member States for work on social determinants of health;

(4) to continue to convey and advocate the importance of integrating social determinants of health perspectives into forthcoming United Nations and other high-level meetings related to health and/or social development;

(5) to report to the Sixty-sixth and Sixty-eighth World Health Assemblies, through the Executive Board, on progress in implementing this resolution and the Rio Political Declaration on Social Determinants of Health.

(Eleventh meeting, 21 January 2012)

EB130.R12 World Immunization Week

The Executive Board,

Having considered the report on the draft global vaccine action plan,¹

¹ Document EB130/21.

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

The Sixty-fifth World Health Assembly,

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

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

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

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

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

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

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

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

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

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

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

(Eleventh meeting, 21 January 2012)

**EB130.R13 Substandard/spurious/falsely-labelled/falsified/
counterfeit medical products**

The Executive Board,

Having considered the report of the Working Group of Member States on Substandard/Spurious/Falsely-Labelled/Falsified/Counterfeit Medical Products and its recommendations,^{1,2}

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

The Sixty-fifth World Health Assembly,

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

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

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

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

¹ Document EB130/22, Annex.

² A definition of “substandard/spurious/falsely-labelled/falsified/counterfeit medical products” has yet to be endorsed by the governing bodies.

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

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

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

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

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

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

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

1. REAFFIRMS the fundamental role of WHO in ensuring the quality, safety and efficacy of medical products; in promoting access to affordable, quality, safe and efficacious medicines; and in supporting national drug regulatory authorities in this area, in particular in developing countries and least-developed countries;
2. REITERATES that WHO should continue to focus on and intensify its measures to make medical products more affordable, strengthening national regulatory authorities and health systems that include national medicine policies, health risk management systems, sustainable financing, human resource development and reliable procurement and supply systems; and to enhance and support work on prequalification and promotion of generics, and efforts in rational selection and use of medical products. In each of these areas, WHO’s function should be: information sharing and awareness creation; norms and standards and technical support to countries on country situation assessment; national policy development; and capacity building, supporting product development and domestic production;
3. FURTHER REITERATES that WHO should increase its efforts to support Member States in strengthening national and regional regulatory infrastructure and capacity;
4. DECIDES to establish a new Member State² mechanism for international collaboration among Member States, from a public health perspective, excluding trade and intellectual property considerations, regarding “substandard/spurious/false-labelled/falsified/counterfeit medical products” in accordance with the goals, objectives and terms of reference annexed to the present resolution;

¹ See subparagraph 11.2 (xii).

² And, where applicable, regional economic integration organizations.

5. FURTHER DECIDES to review the Member State mechanism referred to in paragraph 4 after three years of operation;
6. URGES Member States¹ to:
 - (1) on a voluntary basis, participate in and collaborate with the Member State mechanism referred to in paragraph 4;
 - (2) provide sufficient financial resources to strengthen the work of the Secretariat in this area;
7. REQUESTS the Director-General:
 - (1) to support the Member State mechanism referred to in paragraph 4;
 - (2) to support Member States in building capacity to prevent and control “substandard/spurious/falsely-labelled/falsified/counterfeit medical products”.

¹ And, where applicable, regional economic integration organizations.

ANNEX

**Member State mechanism on substandard/spurious/falsely-labelled/
falsified/counterfeit medical products****Goal, objectives and terms of reference****General goal**

In order to protect public health and promote access to affordable, safe, efficacious and quality medical products, promote, through effective collaboration among Member States and the Secretariat, the prevention and control of substandard/spurious/falsely-labelled/falsified/counterfeit medical products¹ and associated activities.

Objectives

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

¹ The Member State mechanism shall use the term “substandard/spurious/falsely-labelled/falsified/counterfeit medical products” until a definition has been endorsed by the governing bodies of WHO.

(8) To promote cooperation and collaboration on surveillance and monitoring of “substandard/spurious/falsey-labelled/falsified/counterfeit medical products”.

(9) To further develop definitions of “substandard/spurious/falsey-labelled/falsified/counterfeit medical products” that focus on the protection of public health.

Structure

(1) The Member State mechanism will be open to all Member States.¹ The Member State mechanism should include expertise in national health and medical products regulatory matters.

(2) The Member State mechanism may establish subsidiary working groups from among its members to consider and make recommendations on specific issues.

(3) Regional groups will provide input into the Member State mechanism as appropriate.

(4) The Member State mechanism shall make use of existing WHO structures.

Meetings

(1) The Member State mechanism should meet not less than once a year and in additional sessions as needed.

(2) The default venue for the Member State mechanism, and its subsidiary working groups, will be Geneva. Meetings may, however, be held from time to time outside Geneva, taking into account regional distribution, overall cost and cost-sharing, and relevance to the agenda.

Relations with other stakeholders and experts

(1) As needed, the Member State mechanism should seek expert advice on specific topics, following standard WHO procedures for expert groups.

(2) As needed, the Member State mechanism will invite other stakeholders to collaborate and consult with the group on specific topics.

Reporting and review

(1) The functioning of the Member State mechanism shall be reviewed by the World Health Assembly after three years of its operation.

(2) The Member State mechanism shall submit a report to the Health Assembly through the Executive Board on progress and any recommendations annually as a substantive item for the first three years and every two years thereafter.

Transparency and conflict of interest

(1) The Member State mechanism, including all invited experts, should operate in a fully inclusive and transparent manner.

¹ And, where applicable, regional economic integration organizations.

(2) Possible conflicts of interest shall be disclosed and managed in accordance with the policies and practice of WHO.

(Twelfth meeting, 21 January 2012)

EB130.R14 WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies

The Executive Board,

Having considered the report on WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies,¹

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

The Sixty-fifth World Health Assembly,

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

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

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

Recalling Article 2(d) of the Constitution of the World Health Organization on the mandate of WHO in emergencies, and resolutions WHA58.1 on health action in relation to crises and disasters and WHA59.22 on emergency preparedness and response;³

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

¹ Document EB130/24.

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

³ Resolutions WHA34.26, WHA46.6, WHA48.2, WHA58.1, WHA59.22 and WHA64.10 reiterate WHO's role in emergencies.

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

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

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

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

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

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

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

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

Recalling WHO's reform agenda and taking note of the report in 2011 by the Director-General on Reforms for a healthy future,¹ which led to the creation of a new WHO cluster, Polio, Emergencies and Country Collaboration, aimed at supporting regional and country offices to improve outcomes and increase WHO's effectiveness at the country level, by

¹ Document A64/4.

redefining its commitment to emergency work and placing the cluster on a more sustainable budgetary footing;

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

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

1. CALLS ON Member States¹ and donors:

(1) to allocate the resources for the health sector activities during humanitarian emergencies through the United Nations Consolidated Appeal Process and Flash Appeals, and for strengthening WHO's institutional capacity to exercise its role as the Global Health Cluster Lead Agency and to assume the health cluster lead in the field;

(2) to ensure that humanitarian activities are carried out in consultation with the country concerned for an efficient response to the humanitarian needs, and to encourage all humanitarian partners, including nongovernmental organizations, to participate actively in the health cluster coordination;

(3) to strengthen the national level risk management, health emergency preparedness and contingency planning processes and disaster management units in the health ministry, as outlined in resolution WHA64.10, and, in this context, as part of the national preparedness planning, with the Office for the Coordination of Humanitarian Affairs where appropriate, identify in advance the best way to ensure that the coordination between the international humanitarian partners and existing national coordination mechanisms will take place in a complementary manner in order to guarantee an effective and well-coordinated humanitarian response;

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

¹ And, where applicable, regional economic integration organizations.

2. CALLS ON the Director-General:

- (1) to have in place the necessary WHO policies, guidelines, adequate management structures and processes required for effective and successful humanitarian action at the country level, as well as the organizational capacity and resources to enable itself to discharge its function as the Global Health Cluster Lead Agency, in accordance with agreements made by the Inter-Agency Standing Committee Principals; and assume the role of Health Cluster Lead Agency in the field;
- (2) to strengthen WHO's surge capacity, including developing standby arrangements with Global Health Cluster partners, to ensure that WHO has qualified humanitarian personnel to be mobilized at short notice when required;
- (3) to ensure that in humanitarian crises WHO provides Member States and humanitarian partners with predictable support by coordinating rapid assessment and analysis of humanitarian needs, including as a part of the coordinated Inter-Agency Standing Committee response, building an evidence-based strategy and action plan, monitoring the health situation and health sector response, identifying gaps, mobilizing resources and performing the necessary advocacy for humanitarian health action;
- (4) to define the core commitments, core functions and performance standards of the Organization in humanitarian emergencies, including its role as the Global Health Cluster Lead Agency and as Health Cluster Lead Agency in the field, and to ensure full engagement of country, regional and global levels of the Organization to their implementation according to established benchmarks, keeping in mind the ongoing work on the Inter-Agency Standing Committee transformative humanitarian agenda;
- (5) to provide a faster, more effective and more predictable humanitarian response by operationalizing the Emergency Response Framework, keeping the performance benchmarks in line with the humanitarian reform, and to ensure the accountability of its performance against those standards;
- (6) to establish necessary mechanisms to mobilize WHO's technical expertise across all disciplines and levels, for the provision of necessary guidance and support to Member States, as well as partners of the health cluster in humanitarian crises;
- (7) to support Member States and partners in the transition to recovery, aligning the recovery planning, including emergency risk management as well as disaster risk-reduction and preparedness, with the national development policies and ongoing health sector reforms, and/or using the opportunities of post-disaster and/or post-conflict recovery planning;
- (8) to provide leadership at the global level in developing methods for systematic collection and dissemination of data on attacks on health facilities, health workers, health transports, and patients in complex humanitarian emergencies, in coordination with other relevant United Nations bodies, the International Committee of the Red Cross, and intergovernmental and nongovernmental organizations, avoiding duplication of efforts;
- (9) to provide a report to the Sixty-seventh World Health Assembly, through the Executive Board, and thereafter every two years, on progress made in the implementation of this resolution.

EB130.R15 Amendments to the Staff Rules

The Executive Board,

Having considered the report on amendments to the Staff Regulations and Staff Rules,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 January 2012 concerning the remuneration of staff in the professional and higher categories, including the revised rates of staff assessment in conjunction with gross base salaries; and with effect from 1 February 2012 regarding medical examination.²

(Thirteenth meeting, 23 January 2012)

EB130.R16 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,³

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

The Sixty-fifth World Health Assembly,

Noting the recommendations of the Executive Board with regard to remuneration of staff in ungraded posts and of the Director-General,²

1. ESTABLISHES the salaries of Assistant Directors-General and Regional Directors at US\$ 174 214 gross per annum before staff assessment, resulting in a modified net salary of US\$ 133 950 (dependency rate) or US\$ 121 297 (single rate);
2. ESTABLISHES the salary of the Deputy Director-General at US\$ 191 491 gross per annum before staff assessment, resulting in a modified net salary of US\$ 146 044 (dependency rate) or US\$ 131 432 (single rate);
3. ESTABLISHES the salary of the Director-General at US\$ 251 540 gross per annum before staff assessment, resulting in a modified net salary of US\$ 176 501 (dependency rate) or US\$ 156 964 (single rate);
4. DECIDES that those adjustments in remuneration shall take effect on 1 January 2012.

(Thirteenth meeting, 23 January 2012)

¹ Document EB130/28.

² See Annex 4, and Annex 6 for the financial and administrative implications for the Secretariat of the adoption of the resolution.

³ Document EB130/28.

EB130.R17 Relations with nongovernmental organizations¹

The Executive Board,

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

1. DECIDES to admit into official relations with WHO the following nongovernmental organizations: the International Society of Nephrology, the World Hepatitis Alliance, the International Spinal Cord Society, and the Handicap International Federation;
2. DECIDES to discontinue official relations with the International Council of Women, the International Union of Pure and Applied Chemistry, and the Islamic Organization for Medical Sciences.

(Thirteenth meeting, 23 January 2012)

¹ See Annex 5.

² Document EB130/31.

DECISIONS

EB130(1) Implementation of the action plan for the prevention of avoidable blindness and visual impairment

The Executive Board, having considered the report on progress in implementing the action plan for the prevention of avoidable blindness and visual impairment;¹ noting that the current action plan will end in 2013, and being convinced that work should commence immediately on a follow-up plan for the period 2014–2019 to ensure that it can be considered for adoption in a timely way and in alignment with WHO's planning cycles,

- (1) decided that a new action plan for the prevention of avoidable blindness and visual impairment for the period 2014–2019 will be developed;
- (2) requested the Director-General to develop a draft action plan for the prevention of avoidable blindness and visual impairment for the period 2014–2019 in close consultation with Member States and international partners, and to submit this draft action plan for consideration, through the Executive Board at its 132nd session, to the Sixty-sixth World Health Assembly in 2013.

(Ninth meeting, 20 January 2012)

EB130(2) Maternal, infant and young child nutrition: draft comprehensive implementation plan²

The Executive Board, having considered the report on maternal, infant and young child nutrition: draft comprehensive implementation plan,³ as well as the report on nutrition of women in the preconception period, during pregnancy and the breastfeeding period,⁴ expressing appreciation for the work completed to date, and noting the draft resolution contained in document EB130/Conf.Paper No. 4,⁵

- (1) requested the Director-General to conduct, as soon as possible, further consultations regarding the targets within the existing draft comprehensive implementation plan via a web-based process open to all Member States,⁶ as well as multilateral organizations, to provide further guidance in the finalization of the comprehensive implementation plan;
- (2) decided that the Director-General should finalize the implementation plan on maternal, infant and young child nutrition in time for consideration by the Sixty-fifth World Health Assembly in May 2012, as set forth in resolution WHA63.23;

¹ Document EB130/8.

² See Annex 6 for the financial and administrative implications for the Secretariat of the adoption of the decision.

³ Document EB130/10.

⁴ Document EB130/11.

⁵ Included below.

⁶ And, where applicable, regional economic integration organizations.

(3) encouraged informal consultations among Member States¹ on the basis of the draft resolution contained in document EB130/Conf.Paper No.4 proposing the endorsement of the comprehensive implementation plan by the Sixty-fifth World Health Assembly.

Agenda item 6.3

**EB130/Conf.Paper No.4
17 January 2012**

**Maternal, infant and young child nutrition:
draft comprehensive implementation plan**

Draft resolution proposed by Chile, Ecuador, Peru and Poland

The Executive Board,

Having considered the report on maternal, infant and young child nutrition: draft comprehensive implementation plan,² as well as the report on nutrition of women in the preconception period, during pregnancy and the breastfeeding period,³

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

The Sixty-fifth World Health Assembly,

PP1 Having considered the report on maternal, infant and young child nutrition: draft comprehensive implementation plan, as well as the report on nutrition of women in the preconception period, during pregnancy and breastfeeding;

PP2 Recalling resolutions WHA30.51 and WHA31.47 on the role of the health sector in the development of national and international food and nutrition policies and plans; WHA46.7 on the follow-up action to the International Conference on Nutrition; WHA35.26, WHA37.30, WHA39.28, WHA41.11, WHA43.3, WHA44.33, WHA45.34, WHA46.7, WHA47.5, WHA49.15, WHA54.2, WHA55.25, WHA58.32, WHA59.21, WHA61.20 and WHA63.23 on infant and young child nutrition; and WHA46.7 and WHA59.11 on nutrition and HIV/AIDS;

PP3 Conscious that poor availability of, or access to, food of adequate nutritional quality or the exposure to conditions that impair absorption and use of nutrients has led to large sections of the world's population being undernourished, having poor vitamin and mineral status or being overweight and obese;

PP4 Aware that anaemia, mainly due to iron deficiency, affects 468 million women of reproductive age, also that 20 million children are born annually with low birth weight, 171 million children under the age of five years had stunted growth and 43 million children younger than five years were overweight globally in 2010;

¹ And, where applicable, regional economic integration organizations.

² Document EB130/10.

³ Document EB130/11.

PP5 Concerned that maternal and child undernutrition account for 11% of the global burden of disease and has a negative impact on cognitive development, school and physical performance and productivity;

PP6 Convinced of the impact of a well-balanced and culturally acceptable women's diet before conception, during pregnancy and breastfeeding, supplying a sufficient amount of energy, protein and vitamins, as well as micro- and macro-nutrients (e.g. iron, iodine, calcium and vitamin D) on the life and health of both mothers and children;

PP7 Conscious that improper nutrition before conception may cause pregnancy disorders, contribute to the risk of several diseases, and exert a direct influence on child mortality and morbidity, and aware that taking folic acid in the pre- and peri-conception period plays a significant role in protection against congenital malformations, including neural tube defects in newborns;

PP8 Convinced of the need to eliminate use of alcohol, tobacco and psychotropic substances, and to control better the intake of medicines in pregnant women, as they may increase the risk of low birth weight, congenital malformations or miscarriage and increase morbidity in children;

PP9 Mindful that breastfeeding is the best source of nutrition for infants in the first six months of life and a major contribution for proper health and development for up to two years of age and beyond, as well as that appropriate nutrition in the first years of life has a significant influence on health and intellectual development at subsequent development stages;

PP10 Recognizing that policies often do not address the complexity of the challenges of maternal, infant and young child nutrition and do not produce the expected impact;

PP11 Recognizing that effective policies and programmes on nutrition exist but are not implemented on a sufficiently large scale,

1. ENDORSES the comprehensive implementation plan on maternal, infant and young child nutrition;

2. URGES Member States:

(1) to develop national targets and to commit resources in order to achieve, by the year 2022:¹

(a) a 40% reduction in the prevalence of stunting in children under the age of five years globally;

(b) a 50% reduction in the prevalence of anaemia in women of reproductive age globally;

(c) a 50% reduction in the prevalence of low birth weight globally;

(d) no further increase in the prevalence of childhood overweight;

¹ From 2010 baseline data.

-
- (e) an increase in exclusive breastfeeding rates of infants under the age of six months to 50% at global level;
- (2) to put into practice the comprehensive implementation plan on maternal, infant and young child nutrition and, in particular:
- (a) to revise nutrition policies to include nutrition actions in the overall country health and development policy and establish effective intersectoral governance mechanisms in order to expand the implementation of nutrition actions;
 - (b) to review sectoral policies in the agriculture, social welfare, education and trade sectors in order to determine their impact on nutrition;
 - (c) to include effective and safe nutrition actions in maternal, child and adolescent health services and ensure universal coverage of these actions, particularly to underprivileged populations;
 - (d) to develop or strengthen legislative measures for controlling the marketing of breast-milk substitutes;
 - (e) to implement a comprehensive approach to enhancing the capabilities of health workers and managers to deliver nutrition actions;
 - (f) to implement sustainable financing mechanisms for funding the expansion and the sustained implementation of nutrition programmes;
 - (g) to develop or strengthen surveillance systems for the collection of information on indicators of inputs, outputs and outcomes, and impact of nutrition actions;
3. REQUESTS the Director-General:
- (1) to review, update and expand WHO's guidance and tools on effective nutrition actions, analyse their cost-effectiveness, illustrate good practice of delivery mechanisms and adequately disseminate the information;
 - (2) to develop guidance and describe successful examples of multisectoral policy measures on nutrition;
 - (3) to support Member States, on request, in strengthening national health and development policies that include proven nutrition actions; developing technical and managerial capacities and capabilities in nutrition; strengthening legislative, regulatory or other effective measures to control the marketing of breast-milk substitutes and monitoring their implementation;
 - (4) to develop guidelines on the marketing of complementary foods;
 - (5) to engage with multiple partners at global and country levels for expanding nutrition actions;

(6) to report to the Health Assembly, through the Executive Board, in even-numbered years on progress in applying the comprehensive implementation plan on maternal, infant and young child nutrition, together with the report on progress in implementing the Code of Marketing Breast-milk Substitutes.

(Ninth meeting, 20 January 2012)

EB130(3) Global mass gatherings: implications and opportunities for global health security

The Executive Board, having considered the report on global mass gatherings: implications and opportunities for global health security,¹ recognizing that mass gatherings have significant implications for public health beyond the acute public health events which may occur and require rapid detection and effective management; recognizing that the planning and organization of mass gatherings is the responsibility of the Member States; building on the existing WHO resources to support the planning and conduct of mass gathering events; and acknowledging the challenges of some Member States in managing mass gatherings and the expertise of Saudi Arabia, which manages the largest annual recurring mass gathering event, attracting close to 10 million people from more than 180 countries across the globe,

- (1) requested the Director-General to further develop and disseminate multisectoral guidance on planning, management, evaluation and monitoring of all types of mass gathering events with specific emphasis on sustainable preventive measures including health education and preparedness;
- (2) decided that the Director-General should, where appropriate, work closely with Member States that are planning and conducting mass gatherings, in order to support cooperation and communication between the concerned health authorities in each country, and help Member States strengthening functional capacities to better utilize the International Health Regulations (2005) to that end;
- (3) encouraged the Director-General to reach out to non-profit-making, nongovernmental and civil society organizations, including, as appropriate, the private sector in health education related to mass gatherings;
- (4) requested the Director-General to raise awareness on the health impact of mass gatherings and support countries in developing, disseminating and evaluating effective communication strategies, including, as appropriate, social media, around key public health messages.

(Eleventh meeting, 21 January 2012)

EB130(4) Towards the elimination of measles

The Executive Board, taking note of the widespread outbreaks of measles in several WHO regions over the past two years, which have had a devastating impact on the lives of many young children and which further compromise progress towards the achievement of Millennium Development Goal 4 (Reducing child mortality); and considering that, in addition to the existing global approved immunization strategies, five of WHO's six regions have established target dates for

¹ Document EB130/17.

the elimination of measles, yet measles outbreaks continue to pose serious challenges to the achievement of those targets,

- (1) requested the Director-General to emphasize that measles remains a serious threat to childhood health globally in the upcoming global vaccine action plan for the Decade of Vaccines 2011–2020, to be considered for adoption by the Sixty-fifth World Health Assembly in May 2012;
- (2) decided to include ambitious immunization coverage targets and measles elimination goals in the global vaccine action plan;
- (3) called upon Member States and other partners to commit themselves to fulfilling their responsibilities, as stated in the existing regional measles elimination targets and 2015 global measles mortality reduction goals, in order to prevent further devastating outbreaks of measles in the future.

(Eleventh meeting, 21 January 2012)

EB130(5) United Nations Conference on Sustainable Development (Rio+20)

The Executive Board, recalling Principle 1 of the Rio Declaration on Environment and Development (1992), which states “Human beings are at the centre of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature”; acknowledging that economic, social and environmental objectives are mutually supportive; noting the two main themes of the United Nations Conference on Sustainable Development, namely the green economy in the context of sustainable development and poverty eradication and; the institutional framework for sustainable development; recalling the WHO World Conference on Social Determinants of Health and, particularly, the Rio Declaration; and noting also the submissions by the Director-General to the United Nations Conference on Sustainable Development Bureau,

- (1) decided to convene informal discussions among Member States on the contribution submitted by WHO to the forthcoming deliberations of the United Nations Conference on Sustainable Development with a view to ensuring that health is appropriately considered in the Conference proceedings while fully respecting the ongoing negotiations in New York;
- (2) requested the Director-General to facilitate discussions among Member States and organize an informal meeting with Permanent Missions to the United Nations Office and other International Organizations in Geneva for that purpose.

(Thirteenth meeting, 23 January 2012)

EB130(6) WHO reform (programmes and priority setting)

The Executive Board, having considered decision EBSS2(1),

(1) decided on the following scope of work and terms of reference for the Member State¹-driven process established to provide recommendations on methods for programmes and priority setting for the consideration of the Sixty-fifth World Health Assembly in May 2012;

(a) the scope of work will be: to make recommendations to the Sixty-fifth World Health Assembly on the categories, methodology, criteria and timeline for programmes and priority setting in order to serve as guidance for the development of the next and future general programmes of work, recognizing the important linkages to other elements of the WHO reform process;

(b) the specific objectives of the process will be:

(i) to review and consider proposals on priority setting contained in document EB130/5 Add.1 taking as a basis for priority setting: country needs, the relevance of WHO for all countries, its specific comparative advantage and its leading role in global health;

(ii) to elaborate methodology, criteria and the timeline for the priority-setting process;

(iii) to consider possible ways of grouping WHO's work into categories, including but not limited to the seven categories contained in document EB130/5 Add.1, as proposed for the framework for the next general programme of work;

(iv) to identify additional analytical work for the Secretariat emerging from these discussions, which will contribute to the development of the next and future general programmes of work;

(c) the process will be open to all Member States,¹ chaired by Mr R. El Makkaoui, Chairman of the Executive Board and any other officers deemed necessary will be determined by the Officers of the Executive Board;

(d) a meeting will be held on 27 and 28 February 2012 at WHO headquarters to advance the work of the Member State¹-driven process, with any follow-up meetings or discussions, as necessary, to be agreed at that meeting in order to finalize the work before the Sixty-fifth World Health Assembly;

(e) the Chairman of the Member State¹-driven process shall submit a report on the results of the process to the Sixty-fifth World Health Assembly;

(2) requested the following support from the Director-General, based on existing information:

¹ And, where applicable, regional economic integration organizations.

(a) a presentation on current priority-setting practices and the strengths and weaknesses of those practices and the relationship between the country cooperation strategies, the general programme of work formulation process and the programme and budgeting process, to be held on the afternoon of 26 February 2012. Copies of the presentation are to be circulated three days in advance of the presentation. Arrangements are to be made for a web-based consultation for nongovernmental organizations in official relations with WHO to present their views according to the scope of work and for them to observe the presentation;

(b) no fewer than seven days in advance of the meeting on 27 and 28 February, the following documents are to be provided:

(i) a three-page summary paper on the presentation described in subparagraph (2)(a) above;

(ii) mapping of the functions of the Organization (Article 2, WHO Constitution) in relation to the categories proposed in document EB130/5 Add.1, including cross-cutting global needs and areas of work;

(iii) an analysis of country cooperation strategies that identifies the needs of countries in a way that allows a determination of what WHO should focus its work on and where WHO is best placed to add value;

(iv) a road map and timelines for the preparation of the Twelfth General Programme of Work and the Programme budget 2014–2015;

(v) reference documents including, in particular, the following:

- Eleventh General Programme of Work, 2006–2015;
- Medium-term Strategic Plan 2008–2013 (amended);
- Documents EB130/5 Add.1 and Add.2;
- Document EBSS/2/2 and decision EBSS2(1);
- Document EB118/7 on strategic resource allocation;
- *World health statistics 2011* (which provides information on disease burden).

(Thirteenth meeting, 23 January 2012)

EB130(7) Election of the Director-General of the World Health Organization: report of the Working Group

The Executive Board, having considered the report of the Working Group of Member States on the Process and Methods of the Election of the Director-General of the World Health Organization,¹ and its recommendation contained in paragraph 24 of the report, decided to convene a follow-up session of the Working Group to further explore discussed proposals and finalize its work ahead of the Sixty-fifth World Health Assembly.

(Thirteenth meeting, 23 January 2012)

EB130(8) Review of nongovernmental organizations in official relations with WHO

The Executive Board, having considered and noted the report of its Standing Committee on Nongovernmental Organizations² concerning the review of one third of the nongovernmental organizations in official relations with WHO, and following up decision EB128(1), reached the decisions set out below,

- (1) noting with appreciation their collaboration with WHO and commending the continuing dedication to the work of WHO, the Board decided to maintain in official relations with WHO the nongovernmental organizations whose names are followed by an asterisk in the Annex to the report;
- (2) noting that a plan for collaboration had been agreed, the Board decided to maintain the International Special Dietary Foods Industries in official relations with WHO;
- (3) noting that agreed plans for collaboration are yet to be finalized, the Board decided to defer the review of relations with CropLife International and La Leche League International, until its 132nd session, at which time reports, either on agreed plans for collaboration or status of relations, would be considered;
- (4) noting the report, and to encourage a successful outcome to continuing efforts to agree a plan for collaboration, the Board decided to defer the review of relations with the International Federation of Biomedical Laboratory Science by one year, until its 132nd session, and further requested that the Federation be informed that, in the absence of an agreed plan for collaboration, official relations would be discontinued.

(Thirteenth meeting, 23 January 2012)

EB130(9) 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 2012 to Dr Shaikha Salim Al Arrayed from Bahrain for her significant contribution to public health in Bahrain, in particular the control of genetic diseases. The laureate will receive the equivalent of 2500 Swiss francs in United States dollars.

(Thirteenth meeting, 23 January 2012)

¹ Document EB130/29 Corr.1.

² Document EB130/31.

EB130(10) Award of the Ihsan Dođramacı Family Health Foundation Prize

The Executive Board, having considered the report of the Ihsan Dođramacı Family Health Foundation Selection Panel awarded the Ihsan Dođramacı Family Health Foundation Prize for 2012 to Dr Ayse Akin from Turkey for her long-standing career in the area of family health in Turkey. The laureate will receive US\$ 20 000.

(Thirteenth meeting, 23 January 2012)

EB130(11) 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 2012 to the Syamsi Dhuha Foundation of Indonesia for its work in improving the quality of life of people living with lupus and poor vision. The laureate, as an organization, will receive US\$ 40 000.

(Thirteenth meeting, 23 January 2012)

EB130(12) 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 2012 to both Dr Chen Bowen from China for his important contribution to the establishment of community health services in China and to the Renal Disease Control Program of the Philippines, which takes charge of implementing the public health projects of the National Kidney Transplant Institute in the Philippines on the prevention and control of renal and related diseases. The laureates will each receive US\$ 20 000.

(Thirteenth meeting, 23 January 2012)

EB130(13) 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 2012 to Dr Eltahir Medani Elshibly from Sudan for his dedication to a wide range of family health issues, from breastfeeding promotion to HIV prevention and nutrition. The laureate will receive US\$ 20 000.

(Thirteenth meeting, 23 January 2012)

EB130(14) 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 Public Health for 2012 to the Pacific Leprosy Foundation based in New Zealand for its outstanding contribution to public health. The laureate will receive US\$ 100 000.

(Thirteenth meeting, 23 January 2012)

EB130(15) Membership of the Independent Expert Oversight Advisory Committee

The Executive Board, having considered the report by the Secretariat on membership of the Independent Expert Oversight Advisory Committee,¹ and having taken into account the terms of reference of the Independent Expert Oversight Advisory Committee, decided the following:

- (1) to agree to the second option proposed by the Director-General in paragraph 9 of the report, namely, that the terms of office of Mr Miller and Ms Ploix not be renewed;
- (2) to request the Director-General to propose two candidates to the Officers of the Executive Board, taking into account subparagraph 3(j) of the terms of reference of the Independent Expert Oversight Advisory Committee, and if possible making the proposal before the next meeting of the Committee;
- (3) to give the Officers of the Executive Board the authority to provisionally approve the proposed two new members of the Independent Expert Oversight Advisory Committee, with the understanding that final approval is to be given by the Executive Board at its 131st session in May 2012;
- (4) to request the Director-General that, following the provisional approval by the Officers of the Board of the two new members of the Independent Expert Oversight Advisory Committee, their names and biographical information would be shared with all Executive Board members as soon as possible.

(Fourteenth meeting, 23 January 2012)

EB130(16) Provisional agenda for the Sixty-fifth World Health Assembly

The Executive Board, having considered the report of the Director-General on the provisional agenda for the Sixty-fifth World Health Assembly,² and recalling its earlier decision that the Sixty-fifth World Health Assembly should be held at the Palais des Nations in Geneva, opening on Monday, 21 May 2012, and closing no later than Saturday, 26 May 2012,³ approved the provisional agenda of the Sixty-fifth World Health Assembly, as amended.

(Fourteenth meeting, 23 January 2012)

¹ Document EB130/30.

² Document EB130/33.

³ See decision EB129(7).

EB130(17) Date and place of the 131st session of the Executive Board

The Executive Board decided that its 131st session should be convened on 28 and 29 May 2012, at WHO headquarters, Geneva. The Board further decided that the sixteenth meeting of the Programme, Budget and Administration Committee would be held from 16 to 18 May 2012 at WHO headquarters.

(Fourteenth meeting, 23 January 2012)

ANNEXES

ANNEX 1

Draft contract of the Director-General¹

[EB130/3, Annex – 8 December 2011]

THIS CONTRACT is made this day of between the World Health Organization (hereinafter called the Organization) of the one part and (hereinafter called the Director-General) of the other part.

WHEREAS

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

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

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

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

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

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

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

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

¹ See resolution EB130.R5.

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

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

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

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

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

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

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

.....
Director-General

.....
President of the
World Health Assembly

ANNEX 2

Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases¹

[EB130/6, Annex – 8 December 2011]

We, Heads of State and Government and representatives of States and Governments, assembled at the United Nations on 19 and 20 September 2011, to address the prevention and control of non-communicable diseases worldwide, with a particular focus on developmental and other challenges and social and economic impacts, particularly for developing countries,

1. Acknowledge that the global burden and threat of non-communicable diseases constitutes one of the major challenges for development in the twenty-first century, which undermines social and economic development throughout the world and threatens the achievement of internationally agreed development goals;
2. Recognize that non-communicable diseases are a threat to the economies of many Member States and may lead to increasing inequalities between countries and populations;
3. Recognize the primary role and responsibility of Governments in responding to the challenge of non-communicable diseases and the essential need for the efforts and engagement of all sectors of society to generate effective responses for the prevention and control of non-communicable diseases;
4. Recognize also the important role of the international community and international cooperation in assisting Member States, particularly developing countries, in complementing national efforts to generate an effective response to non-communicable diseases;
5. Reaffirm the right of everyone to the enjoyment of the highest attainable standard of physical and mental health;
6. Recognize the urgent need for greater measures at the global, regional and national levels to prevent and control non-communicable diseases in order to contribute to the full realization of the right of everyone to the highest attainable standard of physical and mental health;
7. Recall the relevant mandates of the General Assembly, in particular resolutions 64/265 of 13 May 2010 and 65/238 of 24 December 2010;
8. Note with appreciation the World Health Organization Framework Convention on Tobacco Control,² reaffirm all relevant resolutions and decisions adopted by the World Health Assembly on the prevention and control of non-communicable diseases, and underline the importance for Member States to continue addressing common risk factors for non-communicable diseases through the

¹ United Nations General Assembly resolution 66/2, Annex.

² United Nations, *Treaty Series*, vol. 2302, No. 41032.

implementation of the World Health Organization 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases¹ as well as the Global Strategy on Diet, Physical Activity and Health,² and the Global Strategy to Reduce the Harmful Use of Alcohol;³

9. Recall the ministerial declaration adopted at the 2009 high-level segment of the Economic and Social Council,⁴ in which a call was made for urgent action to implement the Global Strategy for the Prevention and Control of Non-communicable Diseases and its related Action Plan;

10. Take note with appreciation of all the regional initiatives undertaken on the prevention and control of non-communicable diseases, including the Declaration of the Heads of State and Government of the Caribbean Community entitled “Uniting to stop the epidemic of chronic non-communicable diseases”, adopted in September 2007, the Libreville Declaration on Health and Environment in Africa, adopted in August 2008, the statement of the Commonwealth Heads of Government on action to combat non-communicable diseases, adopted in November 2009, the declaration of commitment of the Fifth Summit of the Americas, adopted in June 2009, the Parma Declaration on Environment and Health, adopted by the member States in the European region of the World Health Organization in March 2010, the Dubai Declaration on Diabetes and Chronic Non-communicable Diseases in the Middle East and Northern Africa Region, adopted in December 2010, the European Charter on Counteracting Obesity, adopted in November 2006, the Aruba Call for Action on Obesity of June 2011, and the Honiara Communiqué on addressing non-communicable disease challenges in the Pacific region, adopted in July 2011;

11. Take note with appreciation also of the outcomes of the regional multisectoral consultations, including the adoption of ministerial declarations, which were held by the World Health Organization in collaboration with Member States, with the support and active participation of regional commissions and other relevant United Nations agencies and entities, and served to provide inputs to the preparations for the high-level meeting in accordance with resolution 65/238;

12. Welcome the convening of the first Global Ministerial Conference on Healthy Lifestyles and Non-communicable Disease Control, which was organized by the Russian Federation and the World Health Organization and held in Moscow on 28 and 29 April 2011, and the adoption of the Moscow Declaration,⁵ and recall resolution WHA64.11 of the World Health Assembly;⁶

13. Recognize the leading role of the World Health Organization as the primary specialized agency for health, including its roles and functions with regard to health policy in accordance with its mandate, and reaffirm its leadership and coordination role in promoting and monitoring global action against non-communicable diseases in relation to the work of other relevant United Nations agencies, development banks, and other regional and international organizations in addressing non-communicable diseases in a coordinated manner;

¹ Available at <http://www.who.int/publications/en/>.

² World Health Organization, *Fifty-seventh World Health Assembly, Geneva, 17–22 May 2004, Resolutions and Decisions, Annexes* (WHA57/2004/REC/1), resolution 57.17, annex.

³ World Health Organization, *Sixty-third World Health Assembly, Geneva, 17–21 May 2010, Resolutions and Decisions, Annexes* (WHA63/2010/REC/1), annex 3.

⁴ See *Official Records of the General Assembly, Sixty-fourth Session, Supplement No. 3 (A/64/3/Rev.1)*, chap.III, para.56.

⁵ See A/65/859.

⁶ See World Health Organization, *Sixty-fourth World Health Assembly, Geneva, 16–24 May 2011, Resolutions and Decisions, Annexes* (WHA64/2011/REC/1).

A challenge of epidemic proportions and its socio-economic and developmental impacts

14. Note with profound concern that, according to the World Health Organization, in 2008, an estimated 36 million of the 57 million global deaths were due to non-communicable diseases, principally cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, including about 9 million deaths before the age of 60, and that nearly 80 per cent of those deaths occurred in developing countries;
15. Note also with profound concern that non-communicable diseases are among the leading causes of preventable morbidity and of related disability;
16. Recognize further that communicable diseases, maternal and perinatal conditions and nutritional deficiencies are currently the most common causes of death in Africa, and note with concern the growing double burden of disease, including in Africa, caused by the rapidly rising incidence of non-communicable diseases, which are projected to become the most common causes of death by 2030;
17. Note further that there is a range of other non-communicable diseases and conditions, for which the risk factors and the need for preventive measures, screening, treatment and care are linked with the four most prominent non-communicable diseases;
18. Recognize that mental and neurological disorders, including Alzheimer's disease, are an important cause of morbidity and contribute to the global non-communicable disease burden, for which there is a need to provide equitable access to effective programmes and health-care interventions;
19. Recognize that renal, oral and eye diseases pose a major health burden for many countries and that these diseases share common risk factors and can benefit from common responses to non-communicable diseases;
20. Recognize that the most prominent non-communicable diseases are linked to common risk factors, namely tobacco use, harmful use of alcohol, an unhealthy diet and lack of physical activity;
21. Recognize that the conditions in which people live and their lifestyles influence their health and quality of life and that poverty, uneven distribution of wealth, lack of education, rapid urbanization, population ageing and the economic social, gender, political, behavioural and environmental determinants of health are among the contributing factors to the rising incidence and prevalence of non-communicable diseases;
22. Note with grave concern the vicious cycle whereby non-communicable diseases and their risk factors worsen poverty, while poverty contributes to rising rates of non-communicable diseases, posing a threat to public health and economic and social development;
23. Note with concern that the rapidly growing magnitude of non-communicable diseases affects people of all ages, gender, race and income levels, and further that poor populations and those living in vulnerable situations, in particular in developing countries, bear a disproportionate burden and that non-communicable diseases can affect women and men differently;
24. Note with concern the rising levels of obesity in different regions, particularly among children and youth, and note that obesity, an unhealthy diet and physical inactivity have strong linkages with the four main non-communicable diseases and are associated with higher health costs and reduced productivity;

25. Express deep concern that women bear a disproportionate share of the burden of caregiving and that, in some populations, women tend to be less physically active than men, are more likely to be obese and are taking up smoking at alarming rates;

26. Note also with concern that maternal and child health is inextricably linked with non-communicable diseases and their risk factors, specifically as prenatal malnutrition and low birth weight create a predisposition to obesity, high blood pressure, heart disease and diabetes later in life, and that pregnancy conditions, such as maternal obesity and gestational diabetes, are associated with similar risks in both the mother and her offspring;

27. Note with concern the possible linkages between non-communicable diseases and some communicable diseases, such as HIV/AIDS, call for the integration, as appropriate, of responses to HIV/AIDS and non-communicable diseases, and in this regard call for attention to be given to people living with HIV/AIDS, especially in countries with a high prevalence of HIV/AIDS, in accordance with national priorities;

28. Recognize that smoke exposure from the use of inefficient cooking stoves for indoor cooking or heating contributes to and may exacerbate lung and respiratory conditions, with a disproportionate effect on women and children in poor populations whose households may be dependent on such fuels;

29. Acknowledge also the existence of significant inequalities in the burden of non-communicable diseases and in access to non-communicable disease prevention and control, both between countries, and within countries and communities;

30. Recognize the critical importance of strengthening health systems, including health-care infrastructure, human resources for health, and health and social protection systems, particularly in developing countries, in order to respond effectively and equitably to the health-care needs of people with non-communicable diseases;

31. Note with grave concern that non-communicable diseases and their risk factors lead to increased burdens on individuals, families and communities, including impoverishment from long-term treatment and care costs, and to a loss of productivity that threatens household income and leads to productivity loss for individuals and their families and to the economies of Member States, making non-communicable diseases a contributing factor to poverty and hunger, which may have a direct impact on the achievement of the internationally agreed development goals, including the Millennium Development Goals;

32. Express deep concern at the ongoing negative impacts of the financial and economic crisis, volatile energy and food prices and ongoing concerns over food security, as well as the increasing challenges posed by climate change and the loss of biodiversity, and their effect on the control and prevention of non-communicable diseases, and emphasize in this regard the need for prompt and robust, coordinated and multisectoral efforts to address those impacts, while building on efforts already under way;

Responding to the challenge: a whole-of-government and a whole-of-society effort

33. Recognize that the rising prevalence, morbidity and mortality of non-communicable diseases worldwide can be largely prevented and controlled through collective and multisectoral action by all Member States and other relevant stakeholders at the local, national, regional and global levels, and by raising the priority accorded to non-communicable diseases in development cooperation by enhancing such cooperation in this regard;

34. Recognize that prevention must be the cornerstone of the global response to non-communicable diseases;
35. Recognize also the critical importance of reducing the level of exposure of individuals and populations to the common modifiable risk factors for non-communicable diseases, namely, tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol, and their determinants, while at the same time strengthening the capacity of individuals and populations to make healthier choices and follow lifestyle patterns that foster good health;
36. Recognize that effective non-communicable disease prevention and control require leadership and multisectoral approaches for health at the government level, including, as appropriate, health in all policies and whole-of-government approaches across such sectors as health, education, energy, agriculture, sports, transport, communication, urban planning, environment, labour, employment, industry and trade, finance, and social and economic development;
37. Acknowledge the contribution of and important role played by all relevant stakeholders, including individuals, families and communities, intergovernmental organizations and religious institutions, civil society, academia, the media, voluntary associations and, where and as appropriate, the private sector and industry, in support of national efforts for non-communicable disease prevention and control, and recognize the need to further support the strengthening of coordination among these stakeholders in order to improve the effectiveness of these efforts;
38. Recognize the fundamental conflict of interest between the tobacco industry and public health;
39. Recognize that the incidence and impacts of non-communicable diseases can be largely prevented or reduced with an approach that incorporates evidence-based, affordable, cost-effective, population-wide and multisectoral interventions;
40. Acknowledge that resources devoted to combating the challenges posed by non-communicable diseases at the national, regional and international levels are not commensurate with the magnitude of the problem;
41. Recognize the importance of strengthening local, provincial, national and regional capacities to address and effectively combat non-communicable diseases, particularly in developing countries, and that this may entail increased and sustained human, financial and technical resources;
42. Acknowledge the need to put forward a multisectoral approach for health at all government levels, to address non-communicable disease risk factors and underlying determinants of health comprehensively and decisively;

Non-communicable diseases can be prevented and their impacts significantly reduced, with millions of lives saved and untold suffering avoided. We therefore commit to:

Reduce risk factors and create health-promoting environments

43. Advance the implementation of multisectoral, cost-effective, population-wide interventions in order to reduce the impact of the common non-communicable disease risk factors, namely tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol, through the implementation of relevant international agreements and strategies, and education, legislative, regulatory and fiscal measures, without prejudice to the right of sovereign nations to determine and establish their taxation policies and other policies, where appropriate, by involving all relevant sectors, civil society and communities, as appropriate, and by taking the following actions:

- (a) Encourage the development of multisectoral public policies that create equitable health-promoting environments that empower individuals, families and communities to make healthy choices and lead healthy lives;
- (b) Develop, strengthen and implement, as appropriate, multisectoral public policies and action plans to promote health education and health literacy, including through evidence-based education and information strategies and programmes in and out of schools and through public awareness campaigns, as important factors in furthering the prevention and control of non-communicable diseases, recognizing that a strong focus on health literacy is at an early stage in many countries;
- (c) Accelerate implementation by States parties of the World Health Organization Framework Convention on Tobacco Control, recognizing the full range of measures, including measures to reduce consumption and availability, and encourage countries that have not yet done so to consider acceding to the Convention, recognizing that substantially reducing tobacco consumption is an important contribution to reducing non-communicable diseases and can have considerable health benefits for individuals and countries and that price and tax measures are an effective and important means of reducing tobacco consumption;
- (d) Advance the implementation of the Global Strategy on Diet, Physical Activity and Health, including, where appropriate, through the introduction of policies and actions aimed at promoting healthy diets and increasing physical activity in the entire population, including in all aspects of daily living, such as giving priority to regular and intense physical education classes in schools, urban planning and re-engineering for active transport, the provision of incentives for work-site healthy-lifestyle programmes, and increased availability of safe environments in public parks and recreational spaces to encourage physical activity;
- (e) Promote the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol, while recognizing the need to develop appropriate domestic action plans, in consultation with relevant stakeholders, for developing specific policies and programmes, including taking into account the full range of options as identified in the Global Strategy, as well as raise awareness of the problems caused by the harmful use of alcohol, particularly among young people, and call upon the World Health Organization to intensify efforts to assist Member States in this regard;
- (f) Promote the implementation of the World Health Organization Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children,¹ including foods that are high in saturated fats, trans-fatty acids, free sugars or salt, recognizing that research shows that food advertising geared to children is extensive, that a significant amount of the marketing is for foods with a high content of fat, sugar or salt and that television advertising influences children's food preferences, purchase requests and consumption patterns, while taking into account existing legislation and national policies, as appropriate;
- (g) Promote the development and initiate the implementation, as appropriate, of cost-effective interventions to reduce salt, sugar and saturated fats and eliminate industrially produced trans-fats in foods, including through discouraging the production and marketing of foods that contribute to unhealthy diet, while taking into account existing legislation and policies;

¹ World Health Organization, *Sixty-third World Health Assembly, 17–21 May 2010, Resolutions and Decisions, Annexes* (WHA63/2010/REC/1), annex 4.

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- (h) Encourage policies that support the production and manufacture of, and facilitate access to, foods that contribute to healthy diet, and provide greater opportunities for utilization of healthy local agricultural products and foods, thus contributing to efforts to cope with the challenges and take advantage of the opportunities posed by globalization and to achieve food security;
 - (i) Promote, protect and support breastfeeding, including exclusive breastfeeding for about six months from birth, as appropriate, as breastfeeding reduces susceptibility to infections and the risk of undernutrition, promotes the growth and development of infants and young children and helps to reduce the risk of developing conditions such as obesity and non-communicable diseases later in life and, in this regard strengthen the implementation of the International Code of Marketing of Breast-milk Substitutes¹ and subsequent relevant World Health Assembly resolutions;
 - (j) Promote increased access to cost-effective vaccinations to prevent infections associated with cancers, as part of national immunization schedules;
 - (k) Promote increased access to cost-effective cancer screening programmes, as determined by national situations;
 - (l) Scale up, where appropriate, a package of proven, effective interventions, such as health promotion and primary prevention approaches, and galvanize actions for the prevention and control of non-communicable diseases through a meaningful multisectoral response, addressing risk factors and determinants of health;
44. With a view to strengthening its contribution to non-communicable disease prevention and control, call upon the private sector, where appropriate, to:
- (a) Take measures to implement the World Health Organization set of recommendations to reduce the impact of the marketing of unhealthy foods and non-alcoholic beverages to children, while taking into account existing national legislation and policies;
 - (b) Consider producing and promoting more food products consistent with a healthy diet, including by reformulating products to provide healthier options that are affordable and accessible and that follow relevant nutrition facts and labelling standards, including information on sugars, salt and fats and, where appropriate, trans-fat content;
 - (c) Promote and create an enabling environment for healthy behaviours among workers, including by establishing tobacco-free workplaces and safe and healthy working environments through occupational safety and health measures, including, where appropriate, through good corporate practices, workplace wellness programmes and health insurance plans;
 - (d) Work towards reducing the use of salt in the food industry in order to lower sodium consumption;
 - (e) Contribute to efforts to improve access to and affordability of medicines and technologies in the prevention and control of non-communicable diseases;

¹ Available at www.who.int/nutrition/publications/code_english.pdf.

Strengthen national policies and health systems

45. Promote, establish or support and strengthen, by 2013, as appropriate, multisectoral national policies and plans for the prevention and control of non-communicable diseases, taking into account, as appropriate, the 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases and the objectives contained therein, and take steps to implement such policies and plans;

(a) Strengthen and integrate, as appropriate, non-communicable disease policies and programmes into health-planning processes and the national development agenda of each Member State;

(b) Pursue, as appropriate, comprehensive strengthening of health systems that support primary health care and deliver effective, sustainable and coordinated responses and evidence-based, cost-effective, equitable and integrated essential services for addressing non-communicable disease risk factors and for the prevention, treatment and care of non-communicable diseases, acknowledging the importance of promoting patient empowerment, rehabilitation and palliative care for persons with non-communicable diseases and of a life course approach, given the often chronic nature of non-communicable diseases;

(c) According to national priorities, and taking into account domestic circumstances, increase and prioritize budgetary allocations for addressing non-communicable disease risk factors and for surveillance, prevention, early detection and treatment of non-communicable diseases and the related care and support, including palliative care;

(d) Explore the provision of adequate, predictable and sustained resources, through domestic, bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanisms;

(e) Pursue and promote gender-based approaches for the prevention and control of non-communicable diseases founded on data disaggregated by sex and age in an effort to address the critical differences in the risks of morbidity and mortality from non-communicable diseases for women and men;

(f) Promote multisectoral and multi-stakeholder engagement in order to reverse, stop and decrease the rising trends of obesity in child, youth and adult populations, respectively;

(g) Recognize where health disparities exist between indigenous peoples and non-indigenous populations in the incidence of non-communicable diseases and their common risk factors, and that these disparities are often linked to historical, economic and social factors, and encourage the involvement of indigenous peoples and communities in the development, implementation and evaluation of non-communicable disease prevention and control policies, plans and programmes, where appropriate, while promoting the development and strengthening of capacities at various levels and recognizing the cultural heritage and traditional knowledge of indigenous peoples and respecting, preserving and promoting, as appropriate, their traditional medicine, including conservation of their vital medicinal plants, animals and minerals;

(h) Recognize further the potential and contribution of traditional and local knowledge, and in this regard respect and preserve, in accordance with national capacities, priorities, relevant legislation and circumstances, the knowledge and safe and effective use of traditional medicine, treatments and practices, appropriately based on the circumstances in each country;

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- (i) Pursue all necessary efforts to strengthen nationally driven, sustainable, cost-effective and comprehensive responses in all sectors for the prevention of non-communicable diseases, with the full and active participation of people living with these diseases, civil society and the private sector, where appropriate;
- (j) Promote the production, training and retention of health workers with a view to facilitating adequate deployment of a skilled health workforce within countries and regions, in accordance with the World Health Organization Global Code of Practice on the International Recruitment of Health Personnel;¹
- (k) Strengthen, as appropriate, information systems for health planning and management, including through the collection, disaggregation, analysis, interpretation and dissemination of data and the development of population-based national registries and surveys, where appropriate, to facilitate appropriate and timely interventions for the entire population;
- (l) According to national priorities, give greater priority to surveillance, early detection, screening, diagnosis and treatment of non-communicable diseases and prevention and control, and to improving accessibility to safe, affordable, effective and quality medicines and technologies to diagnose and to treat them; provide sustainable access to medicines and technologies, including through the development and use of evidence-based guidelines for the treatment of non-communicable diseases, and efficient procurement and distribution of medicines in countries; and strengthen viable financing options and promote the use of affordable medicines, including generics, as well as improved access to preventive, curative, palliative and rehabilitative services, particularly at the community level;
- (m) According to country-led prioritization, ensure the scaling-up of effective, evidence-based and cost-effective interventions that demonstrate the potential to treat individuals with non-communicable diseases, protect those at high risk of developing them and reduce risk across populations;
- (n) Recognize the importance of universal coverage in national health systems, especially through primary health care and social protection mechanisms, to provide access to health services for all, in particular for the poorest segments of the population;
- (o) Promote the inclusion of non-communicable disease prevention and control within sexual and reproductive health and maternal and child health programmes, especially at the primary health-care level, as well as other programmes, as appropriate, and also integrate interventions in these areas into non-communicable disease prevention programmes;
- (p) Promote access to comprehensive and cost-effective prevention, treatment and care for the integrated management of non-communicable diseases, including, inter alia, increased access to affordable, safe, effective and quality medicines and diagnostics and other technologies, including through the full use of trade-related aspects of intellectual property rights (TRIPS) flexibilities;
- (q) Improve diagnostic services, including by increasing the capacity of and access to laboratory and imaging services with adequate and skilled manpower to deliver such services,

¹ See World Health Organization, *Sixty-third World Health Assembly, 17–21 May 2010, Resolutions and Decisions, Annexes* (WHA63/2010/REC/1), annex 5.

and collaborate with the private sector to improve affordability, accessibility and maintenance of diagnostic equipment and technologies;

(r) Encourage alliances and networks that bring together national, regional and global actors, including academic and research institutes, for the development of new medicines, vaccines, diagnostics and technologies, learning from experiences in the field of HIV/AIDS, among others, according to national priorities and strategies;

(s) Strengthen health-care infrastructure, including for procurement, storage and distribution of medicine, in particular transportation and storage networks to facilitate efficient service delivery;

International cooperation, including collaborative partnerships

46. Strengthen international cooperation in support of national, regional and global plans for the prevention and control of non-communicable diseases, inter alia, through the exchange of best practices in the areas of health promotion, legislation, regulation and health systems strengthening, training of health personnel, development of appropriate health-care infrastructure and diagnostics, and by promoting the development and dissemination of appropriate, affordable and sustainable transfer of technology on mutually agreed terms and the production of affordable, safe, effective and quality medicines and vaccines, while recognizing the leading role of the World Health Organization as the primary specialized agency for health in that regard;

47. Acknowledge the contribution of aid targeted at the health sector, while recognizing that much more needs to be done. We call for the fulfilment of all official development assistance-related commitments, including the commitments by many developed countries to achieve the target of 0.7 per cent of gross national income for official development assistance by 2015, as well as the commitments contained in the Programme of Action for the Least Developed Countries for the Decade 2011–2020,¹ and strongly urge those developed countries that have not yet done so to make additional concrete efforts to fulfil their commitments;

48. Stress the importance of North-South, South-South and triangular cooperation, in the prevention and control of non-communicable diseases, to promote at the national, regional and international levels an enabling environment to facilitate healthy lifestyles and choices, bearing in mind that South-South cooperation is not a substitute for, but rather a complement to, North-South cooperation;

49. Promote all possible means to identify and mobilize adequate, predictable and sustained financial resources and the necessary human and technical resources, and to consider support for voluntary, cost-effective, innovative approaches for a long-term financing of non-communicable disease prevention and control, taking into account the Millennium Development Goals;

50. Acknowledge the contribution of international cooperation and assistance in the prevention and control of non-communicable diseases, and in this regard encourage the continued inclusion of non-communicable diseases in development cooperation agendas and initiatives;

51. Call upon the World Health Organization, as the lead United Nations specialized agency for health, and all other relevant United Nations system agencies, funds and programmes, the international

¹ See *Report of the Fourth United Nations conference on the Least-Developed Countries, Istanbul, Turkey, 9–13 May 2011* (United Nations publication, Sales No. 11.II.A.I), chap.II.

financial institutions, development banks and other key international organizations to work together in a coordinated manner to support national efforts to prevent and control noncommunicable diseases and mitigate their impacts;

52. Urge relevant international organizations to continue to provide technical assistance and capacity-building to developing countries, especially to the least developed countries, in the areas of non-communicable disease prevention and control and promotion of access to medicines for all, including through the full use of trade-related aspects of intellectual property rights flexibilities and provisions;

53. Enhance the quality of aid by strengthening national ownership, alignment, harmonization, predictability, mutual accountability and transparency, and results orientation;

54. Engage non-health actors and key stakeholders, where appropriate, including the private sector and civil society, in collaborative partnerships to promote health and to reduce non-communicable disease risk factors, including through building community capacity in promoting healthy diets and lifestyles;

55. Foster partnerships between government and civil society, building on the contribution of health-related non-governmental organizations and patients' organizations, to support, as appropriate, the provision of services for the prevention and control, treatment and care, including palliative care, of noncommunicable diseases;

56. Promote the capacity-building of non-communicable-disease-related non-governmental organizations at the national and regional levels, in order to realize their full potential as partners in the prevention and control of noncommunicable diseases;

Research and development

57. Promote actively national and international investments and strengthen national capacity for quality research and development, for all aspects related to the prevention and control of non-communicable diseases, in a sustainable and cost-effective manner, while noting the importance of continuing to incentivize innovation;

58. Promote the use of information and communications technology to improve programme implementation, health outcomes, health promotion, and reporting and surveillance systems and to disseminate, as appropriate, information on affordable, cost-effective, sustainable and quality interventions, best practices and lessons learned in the field of non-communicable diseases;

59. Support and facilitate non-communicable-disease-related research and its translation to enhance the knowledge base for ongoing national, regional and global action;

Monitoring and evaluation

60. Strengthen, as appropriate, country-level surveillance and monitoring systems, including surveys that are integrated into existing national health information systems and include monitoring exposure to risk factors, outcomes, social and economic determinants of health, and health system responses, recognizing that such systems are critical in appropriately addressing non-communicable diseases;

61. Call upon the World Health Organization, with the full participation of Member States, informed by their national situations, through its existing structures, and in collaboration with United Nations agencies, funds and programmes and other relevant regional and international organizations, as appropriate, building on continuing efforts to develop, before the end of 2012, a comprehensive global monitoring framework, including a set of indicators, capable of application across regional and country settings, including through multisectoral approaches, to monitor trends and to assess progress made in the implementation of national strategies and plans on non-communicable diseases;

62. Call upon the World Health Organization, in collaboration with Member States through the governing bodies of the World Health Organization, and in collaboration with United Nations agencies, funds and programmes, and other relevant regional and international organizations, as appropriate, building on the work already under way, to prepare recommendations for a set of voluntary global targets for the prevention and control of non-communicable diseases, before the end of 2012;

63. Consider the development of national targets and indicators based on national situations, building on guidance provided by the World Health Organization, to focus on efforts to address the impacts of non-communicable diseases and to assess the progress made in the prevention and control of non-communicable diseases and their risk factors and determinants;

Follow-up

64. Request the Secretary-General, in close collaboration with the Director-General of the World Health Organization, and in consultation with Member States, United Nations funds and programmes and other relevant international organizations, to submit by the end of 2012 to the General Assembly, at its sixty-seventh session, for consideration by Member States, options for strengthening and facilitating multisectoral action for the prevention and control of non-communicable diseases through effective partnership;

65. Request the Secretary-General, in collaboration with Member States, the World Health Organization and relevant funds, programmes and specialized agencies of the United Nations system to present to the General Assembly at its sixty-eighth session a report on the progress achieved in realizing the commitments made in this Political Declaration, including on the progress of multisectoral action, and the impact on the achievement of the internationally agreed development goals, including the Millennium Development Goals, in preparation for a comprehensive review and assessment in 2014 of the progress achieved in the prevention and control of non-communicable diseases.

ANNEX 3

Rio Political Declaration on Social Determinants of Health

Rio de Janeiro, Brazil, 21 October 2011¹

[EB130/15, Annex – 24 November 2011]

1. Invited by the World Health Organization, we, Heads of Government, Ministers and government representatives came together on the 21st day of October 2011 in Rio de Janeiro to express our determination to achieve social and health equity through action on social determinants of health and well-being by a comprehensive intersectoral approach.
2. We understand that health equity is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community, in an “all for equity” and “health for all” global action.
3. We underscore the principles and provisions set out in the World Health Organization Constitution and in the 1978 Declaration of Alma-Ata as well as in the 1986 Ottawa Charter and in the series of international health promotion conferences, which reaffirmed the essential value of equity in health and recognized that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”. We recognize that governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures and that national efforts need to be supported by an enabling international environment.
4. We reaffirm that health inequities within and between countries are politically, socially and economically unacceptable, as well as unfair and largely avoidable, and that the promotion of health equity is essential to sustainable development and to a better quality of life and well-being for all, which in turn can contribute to peace and security.
5. We reiterate our determination to take action on social determinants of health as collectively agreed by the World Health Assembly and reflected in resolution WHA62.14 (“Reducing health inequities through action on the social determinants of health”), which notes the three overarching recommendations of the Commission on Social Determinants of Health: to improve daily living conditions; to tackle the inequitable distribution of power, money and resources; and to measure and understand the problem and assess the impact of action.
6. Health inequities arise from the societal conditions in which people are born, grow, live, work and age, referred to as social determinants of health. These include early years' experiences, education, economic status, employment and decent work, housing and environment, and effective systems of preventing and treating ill health. We are convinced that action on these determinants, both for vulnerable groups and the entire population, is essential to create inclusive, equitable, economically productive and healthy societies. Positioning human health and well-being as one of the key features

¹ See resolution EB130.R11.

of what constitutes a successful, inclusive and fair society in the 21st century is consistent with our commitment to human rights at national and international levels.

7. Good health requires a universal, comprehensive, equitable, effective, responsive and accessible quality health system. But it is also dependent on the involvement of and dialogue with other sectors and actors, as their performance has significant health impacts. Collaboration in coordinated and intersectoral policy actions has proven to be effective. Health in All Policies, together with intersectoral cooperation and action, is one promising approach to enhance accountability in other sectors for health, as well as the promotion of health equity and more inclusive and productive societies. As collective goals, good health and well-being for all should be given high priority at local, national, regional and international levels.

8. We recognize that we need to do more to accelerate progress in addressing the unequal distribution of health resources as well as conditions damaging to health at all levels. Based on the experiences shared at this Conference, we express our political will to make health equity a national, regional and global goal and to address current challenges, such as eradicating hunger and poverty, ensuring food and nutritional security, access to safe drinking water and sanitation, employment and decent work and social protection, protecting environments and delivering equitable economic growth, through resolute action on social determinants of health across all sectors and at all levels. We also acknowledge that by addressing social determinants we can contribute to the achievement of the Millennium Development Goals.

9. The current global economic and financial crisis urgently requires the adoption of actions to reduce increasing health inequities and prevent worsening of living conditions and the deterioration of universal health care and social protection systems.

10. We acknowledge that action on social determinants of health is called for both within countries and at the global level. We underscore that increasing the ability of global actors, through better global governance, promotion of international cooperation and development, participation in policy-making and monitoring progress, is essential to contribute to national and local efforts on social determinants of health. Action on social determinants of health should be adapted to the national and sub-national contexts of individual countries and regions to take into account different social, cultural and economic systems. Evidence from research and experiences in implementing policies on social determinants of health, however, shows common features of successful action. There are five key action areas critical to addressing health inequities: (i) to adopt better governance for health and development; (ii) promote participation in policy-making and implementation; (iii) to further reorient the health sector towards reducing health inequities; (iv) to strengthen global governance and collaboration; and (v) to monitor progress and increase accountability. Action on social determinants of health therefore means that we, the representatives of Governments, will strive individually and collectively to develop and support policies, strategies, programmes and action plans, which address social determinants of health, with the support of the international community, that include:

11. *To adopt better governance for health and development*

11.1 Acknowledging that governance to address social determinants involves transparent and inclusive decision-making processes that give voice to all groups and sectors involved, and develop policies that perform effectively and reach clear and measurable outcomes, build accountability, and, most crucially, are fair in both policy development processes and results;

11.2 We pledge to:

- (i) Work across different sectors and levels of government, including through, as appropriate, national development strategies, taking into account their contribution to

health and health equity and recognizing the leading role of health ministries for advocacy in this regard;

- (ii) Develop policies that are inclusive and take account of the needs of the entire population with specific attention to vulnerable groups and high-risk areas;
- (iii) Support comprehensive programmes of research and surveys to inform policy and action;
- (iv) Promote awareness, consideration and increased accountability of policy-makers for impacts of all policies on health;
- (v) Develop approaches, including effective partnerships, to engage other sectors in order to identify individual and joint roles for improvements in health and reduction of health inequities;
- (vi) Support all sectors in the development of tools and capacities to address social determinants of health at national and international levels;
- (vii) Foster collaboration with the private sector, safeguarding against conflict of interests, to contribute to achieving health through policies and actions on social determinants of health;
- (viii) Implement resolution WHA62.14, which calls for note to be taken of the recommendations of the final report of the Commission on Social Determinants of Health;
- (ix) Strengthen occupational health safety and health protection and their oversight and encourage the public and private sectors to offer healthy working conditions so as to contribute to promoting health for all;
- (x) Promote and strengthen universal access to social services and social protection floors;
- (xi) Give special attention to gender-related aspects as well as early child development in public policies and social and health services;
- (xii) Promote access to affordable, safe, efficacious and quality medicines, including through the full implementation of the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property;
- (xiii) Strengthen international cooperation with a view to promoting health equity in all countries through facilitating transfer on mutually agreed terms of expertise, technologies and scientific data in the field of social determinants of health, as well as exchange of good practices for managing intersectoral policy development.

12. To promote participation in policy-making and implementation

12.1 Acknowledging the importance of participatory processes in policy-making and implementation for effective governance to act on social determinants of health;

12.2 We pledge to:

- (i) Promote and enhance inclusive and transparent decision-making, implementation and accountability for health and health governance at all levels, including through enhancing access to information, access to justice and public participation;
- (ii) Empower the role of communities and strengthen civil society contribution to policy-making and implementation by adopting measures to enable their effective participation for the public interest in decision-making;
- (iii) Promote inclusive and transparent governance approaches, which engage early with affected sectors at all levels of governments, as well as support social participation and involve civil society and the private sector, safeguarding against conflict of interests;
- (iv) Consider the particular social determinants resulting in persistent health inequities for indigenous people, in the spirit of the United Nations Declaration on the Rights of Indigenous Peoples, and their specific needs and promote meaningful collaboration with them in the development and delivery of related policies and programmes;
- (v) Consider the contributions and capacities of civil society to take action in advocacy, social mobilization and implementation on social determinants of health;
- (vi) Promote health equity in all countries particularly through the exchange of good practices regarding increased participation in policy development and implementation;
- (vii) Promote the full and effective participation of developed and developing countries in the formulation and implementation of policies and measures to address social determinants of health at the international level.

13. *To further reorient the health sector towards reducing health inequities*

13.1 Acknowledging that accessibility, availability, acceptability, affordability and quality of health care and public health services are essential to the enjoyment of the highest attainable standard of health, one of the fundamental rights of every human being, and that the health sector should firmly act to reduce health inequities;

13.2 We pledge to:

- (i) Maintain and develop effective public health policies which address the social, economic, environmental and behavioural determinants of health with a particular focus on reducing health inequities;
- (ii) Strengthen health systems towards the provision of equitable universal coverage and promote access to high quality, promotive, preventive, curative and rehabilitative health services throughout the life-cycle, with a particular focus on comprehensive and integrated primary health care;
- (iii) Build, strengthen and maintain public health capacity, including capacity for intersectoral action, on social determinants of health;
- (iv) Build, strengthen and maintain health financing and risk pooling systems that prevent people from becoming impoverished when they seek medical treatment;

- (v) Promote mechanisms for supporting and strengthening community initiatives for health financing and risk pooling systems;
- (vi) Promote changes within the health sector, as appropriate, to provide the capacities and tools to act to reduce health inequities including through collaborative action;
- (vii) Integrate equity, as a priority within health systems, as well as in the design and delivery of health services and public health programmes;
- (viii) Reach out and work across and within all levels and sectors of government by promoting mechanisms for dialogue, problem-solving and health impact assessment with an equity focus to identify and promote policies, programmes, practices and legislative measures that may be instrumental for the goal pursued by this Political Declaration and to adapt or reform those harmful to health and health equity;
- (ix) Exchange good practices and successful experiences with regard to policies, strategies and measures to further reorient the health sector towards reducing health inequities.

14. To strengthen global governance and collaboration

14.1 Acknowledging the importance of international cooperation and solidarity for the equitable benefit of all people and the important role the multilateral organizations have in articulating norms and guidelines and identifying good practices for supporting actions on social determinants, and in facilitating access to financial resources and technical cooperation, as well as in reviewing and, where appropriate, strategically modifying policies and practices that have a negative impact on people's health and well-being;

14.2 We pledge to:

- (i) Adopt coherent policy approaches that are based on the right to the enjoyment of the highest attainable standard of health, taking into account the right to development as referred to, inter alia, by the 1993 Vienna Declaration and Programme of Action, that will strengthen the focus on social determinants of health, towards achieving the Millennium Development Goals;
- (ii) Support social protection floors as defined by countries to address their specific needs and the ongoing work on social protection within the United Nations system, including the work of the International Labour Organization;
- (iii) Support national governments, international organizations, nongovernmental entities and others to tackle social determinants of health as well as to strive to ensure that efforts to advance international development goals and objectives to improve health equity are mutually supportive;
- (iv) Accelerate the implementation by the State Parties of the WHO Framework Convention on Tobacco Control (FCTC), recognizing the full range of measures including measures to reduce consumption and availability, and encourage countries that have not yet done so to consider acceding to the FCTC as we recognize that substantially reducing tobacco consumption is an important contribution to addressing social determinants of health and vice versa;

- (v) Take forward the actions set out in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases at local, national and international levels – ensuring a focus on reducing health inequities;

Support the leading role of the World Health Organization in global health governance, and in promoting alignment in policies, plans and activities on social determinants of health with its partner United Nations agencies, development banks and other key

- (vi) international organizations, including in joint advocacy, and in facilitating access to the provision of financial and technical assistance to countries and regions;
- (vii) Support the efforts of governments to promote capacity and establish incentives to create a sustainable workforce in health and in other fields, especially in areas of greatest need;
- (viii) Build capacity of national governments to address social determinants of health by facilitating expertise and access to resources through appropriate United Nations agencies' support, particularly the World Health Organization;
- (ix) Foster North-South and South-South cooperation in showcasing initiatives, building capacity and facilitating the transfer of technology on mutually agreed terms for integrated action on health inequities, in line with national priorities and needs, including on health services and pharmaceutical production, as appropriate.

15. *To monitor progress and increase accountability*

15.1 Acknowledging that monitoring of trends in health inequities and of impacts of actions to tackle them is critical to achieving meaningful progress, that information systems should facilitate the establishment of relationships between health outcomes and social stratification variables and that accountability mechanisms to guide policy-making in all sectors are essential, taking into account different national contexts;

15.2 We pledge to:

- (i) Establish, strengthen and maintain monitoring systems that provide disaggregated data to assess inequities in health outcomes as well as in allocations and use of resources;
- (ii) Develop and implement robust, evidence-based, reliable measures of societal well-being, building where possible on existing indicators, standards and programmes and across the social gradient, that go beyond economic growth;
- (iii) To promote research on the relationships between social determinants and health equity outcomes with a particular focus on evaluation of effectiveness of interventions;
- (iv) Systematically share relevant evidence and trends among different sectors to inform policy and action;
- (v) Improve access to the results of monitoring and research for all sectors in society;
- (vi) Assess the impacts of policies on health and other societal goals, and take these into account in policy-making;

- (vii) Use intersectoral mechanisms such as a Health in All Policies approach for addressing inequities and social determinants of health; enhance access to justice and ensure accountability, which can be followed up;
- (viii) Support the leading role of the World Health Organization in its collaboration with other United Nations agencies in strengthening the monitoring of progress in the field of social determinants of health and in providing guidance and support to Member States in implementing a Health in All Policies approach to tackling inequities in health;
- (ix) Support the World Health Organization on the follow-up to the recommendations of the Commission on Information and Accountability for Women's and Children's Health;
- (x) Promote appropriate monitoring systems that take into consideration the role of all relevant stakeholders including civil society, nongovernmental organizations as well as the private sector, with appropriate safeguard against conflict of interests, in the monitoring and evaluation process;
- (xi) Promote health equity in and among countries, monitoring progress at the international level and increasing collective accountability in the field of social determinants of health, particularly through the exchange of good practices in this field;
- (xii) Improve universal access to and use of inclusive information technologies and innovation in key social determinants of health.

16. Call for global action

16.1 We, Heads of Government, Ministers and government representatives, solemnly reaffirm our resolve to take action on social determinants of health to create vibrant, inclusive, equitable, economically productive and healthy societies, and to overcome national, regional and global challenges to sustainable development. We offer our solid support for these common objectives and our determination to achieve them.

16.2 We call upon the World Health Organization, United Nations agencies and other international organizations to advocate for, coordinate and collaborate with us in the implementation of these actions. We recognize that global action on social determinants will need increased capacity and knowledge within the World Health Organization and other multilateral organizations for the development and sharing of norms, standards and good practices. Our common values and responsibilities towards humanity move us to fulfil our pledge to act on social determinants of health. We firmly believe that doing so is not only a moral and a human rights imperative but also indispensable to promote human well-being, peace, prosperity and sustainable development. We call upon the international community to support developing countries in the implementation of these actions through the exchange of best practices, the provision of technical assistance and in facilitating access to financial resources, while reaffirming the provisions of the United Nations Millennium Declaration as well as the Monterrey Consensus of the International Conference on Financing for Development.

16.3 We urge those developed countries which have pledged to achieve the target of 0.7 percent of GNP for official development assistance by 2015, and those developed countries that have not yet done so, to make additional concrete efforts to fulfil their commitments in this regard. We also urge developing countries to build on progress achieved in ensuring that official development assistance is used effectively to help achieve development goals and targets.

16.4 World leaders will soon gather again here in Rio de Janeiro to consider how to meet the challenge of sustainable development laid down twenty years ago. This Political Declaration recognizes the important policies needed to achieve both sustainable development and health equity through acting on social determinants.

16.5 We recommend that the social determinants approach is duly considered in the ongoing reform process of the World Health Organization. We also recommend that the Sixty-fifth World Health Assembly adopts a resolution endorsing this Political Declaration.

ANNEX 4

Confirmation of amendments to the Staff Rules¹

[EB130/28 – 8 December 2011]

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-sixth session, on the basis of recommendations made by the International Civil Service Commission in its annual report for 2011.³ Should the United Nations General Assembly not approve the Commission's recommendations, an addendum to the present document will be issued.
3. The amendment described in section II of this document is made in the light of experience and in the interest of good human resources management.
4. The amendments for the biennium 2012–2013 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 Rule is set out in [Appendix 1].

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

Remuneration of staff in the professional and higher categories

6. 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 0.13% 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 2012.
7. The Commission also recommended to the General Assembly the revised staff assessment rates used in conjunction with gross base salaries [see Appendix 2] and that the rates be reviewed every three years and revised as appropriate.

¹ See resolutions EB130.R15 and EB130.R16.

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

³ Report of the International Civil Service Commission for 2011. *General Assembly Official Records, Sixty-sixth session, Supplement No. 30* (document A/66/30).

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

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 6 above, the Director-General proposes, in accordance with Staff Regulation 3.1, that the Executive Board should recommend to the Sixty-fifth World Health Assembly modifications in the salaries of Assistant Directors-General and Regional Directors. Thus, as from 1 January 2012, the gross salary for Assistant Directors-General and Regional Directors would be US\$ 174 214 per annum, and the net salary US\$ 133 950 (dependency rate) or US\$ 121 297 (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 2012, a gross salary of US\$ 191 491 per annum with a corresponding net salary of US\$ 146 044 (dependency rate) or US 131 432 (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 2012, would therefore be US\$ 251 540 per annum gross, US\$ 176 501 net (dependency rate) or US\$ 156 964 net (single rate).

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

Amendments to the Staff Rules

Medical examination on separation

12. Staff Rule 1085 has been amended to provide that at the Organization's request staff members will undergo medical examinations prior to separation from the Organization.

ACTION BY THE EXECUTIVE BOARD

13. [This paragraph contained two draft resolutions, which were adopted at the thirteenth meeting as EB130.R15 and EB130.R16.]

Appendix 1

TEXT OF AMENDED STAFF RULE

1085. MEDICAL EXAMINATION ON SEPARATION

Prior to separation, a staff member may be required to undergo a medical examination by the Staff Physician or by a physician designated by the Organization. If a staff member fails to undergo this medical examination within a reasonable time limit fixed by the Organization, then claims against the Organization arising out of illness or injury which allegedly occurred before the effective date of separation shall not be entertained; furthermore, the effective date of separation shall not be affected

Appendix 1 Attachment

Salary scale for 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 2012)

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	143 282	146 278	149 275	152 370	155 494	158 619									
Net D	112 096	114 283	116 471	118 659	120 846	123 033									
Net S	102 981	104 827	106 666	108 500	110 329	112 147									
					*	*	*	*	*						
D-1 Gross	131 101	133 733	136 359	138 990	141 623	144 252	146 885	149 514	152 236						
Net D	103 204	105 125	107 042	108 963	110 885	112 804	114 726	116 645	118 565						
Net S	95 394	97 062	98 728	100 388	102 047	103 702	105 349	106 996	108 638	*	*	*			
P-5 Gross	108 773	111 010	113 249	115 485	117 725	119 960	122 201	124 438	126 677	128 915	131 153	133 390	135 630		
Net D	86 904	88 537	90 172	91 804	93 439	95 071	96 707	98 340	99 974	101 608	103 242	104 875	106 510		
Net S	80 734	82 186	83 633	85 079	86 524	87 963	89 402	90 838	92 272	93 703	95 132	96 556	97 981		
														*	*
P-4 Gross	89 568	91 616	93 662	95 709	97 758	99 804	101 955	104 114	106 274	108 432	110 595	112 751	114 911	117 073	119 233
Net D	72 467	74 044	75 620	77 196	78 774	80 349	81 927	83 503	85 080	86 655	88 234	89 808	91 385	92 963	94 540
Net S	67 483	68 918	70 354	71 784	73 215	74 645	76 074	77 500	78 924	80 349	81 770	83 191	84 612	86 030	87 447
														*	*
P-3 Gross	73 495	75 390	77 286	79 179	81 077	82 970	84 864	86 762	88 657	90 552	92 449	94 342	96 240	98 134	100 029
Net D	60 091	61 550	63 010	64 468	65 929	67 387	68 845	70 307	71 766	73 225	74 686	76 143	77 605	79 063	80 521
Net S	56 091	57 433	58 777	60 118	61 462	62 803	64 143	65 488	66 828	68 170	69 508	70 847	72 182	73 521	74 859
												*			
P-2 Gross	60 157	61 853	63 547	65 244	66 939	68 632	70 330	72 022	73 718	75 416	77 109	78 805			
Net D	49 821	51 127	52 431	53 738	55 043	56 347	57 654	58 957	60 263	61 570	62 874	64 180			
Net S	46 730	47 915	49 096	50 279	51 461	52 645	53 847	55 046	56 251	57 452	58 650	59 854			
P-1 Gross	46 951	48 448	49 936	51 564	53 190	54 818	56 449	58 081	59 705	61 335					
Net D	39 439	40 696	41 946	43 204	44 456	45 710	46 966	48 222	49 473	50 728					
Net S	37 202	38 359	39 516	40 671	41 827	42 982	44 138	45 280	46 416	47 553					

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

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

Appendix 2

**STAFF ASSESSMENT RATES TO BE USED IN CONJUNCTION
WITH GROSS BASE SALARIES**

Gross base salaries for staff in the professional and higher categories shall be subject to the following assessments:

Staff assessment rates for staff members with dependants (as defined in Staff Rule 310.5.1 and Staff Rule 310.5.2)

<i>Assessable income (United States dollars)</i>	<i>Assessment rate (Percentage)</i>
First 50 000	16
Next 50 000	23
Next 50 000	27
Remaining assessable payments	30

Staff assessment rates for staff members without dependants

Amounts of staff assessments for staff members with neither a dependent spouse nor a dependent child would be equal to the difference between the gross salaries at different grades and steps and the corresponding net salaries at the single rate.

ANNEX 5

Nongovernmental organizations admitted into, or maintained in, official relations with WHO by virtue of resolution EB130.R17 and decision EB130(8)

[EB130/31, Annex – 23 January 2012]

Caritas Internationalis*
CBM*
CropLife International
European Centre for Ecotoxicology and Toxicology of Chemicals*
FDI World Dental Federation*
Handicap International Federation
Helen Keller International*
International Agency for the Prevention of Blindness*
International AIDS Society*
International Air Transport Association*
International Association for Dental Research*
International Association for the Study of Pain*
International Association of Logopedics and Phoniatrics*
International Clearinghouse for Birth Defects Surveillance and Research*
International Commission on Non-Ionizing Radiation Protection*
International Commission on Radiological Protection*
International Council of Ophthalmology*
International Diabetes Federation*
International Eye Foundation¹*
International Federation of Biomedical Laboratory Science
International Federation of Oto-Rhino-Laryngological Societies*
International Leprosy Association*
International Life Sciences Institute*
International Medical Corps*
International Network for Cancer Treatment and Research*
International Network on Children's Health, Environment and Safety*
International Society for Environmental Epidemiology*
International Society of Doctors for the Environment*
International Society of Nephrology
International Solid Waste Association*
International Special Dietary Foods Industries
International Spinal Cord Society
International Union against Sexually Transmitted Infections*
International Union against Tuberculosis and Lung Disease*
International Union of Immunological Societies*
International Union of Toxicology*
International Water Association*
La Leche League International

¹ Previously known as the International Eye Foundation, Inc.

March of Dimes Foundation*
Organisation pour la Prévention de la Cécité*
ORBIS International*
Rotary International*
Stichting Global Network of People Living with HIV/AIDS (GNP+)*
Thalassaemia International Federation*
The International Association of Lions Clubs*
The International Federation of Anti-Leprosy Associations*
The Royal Commonwealth Society for the Blind (Sightsavers)¹*
Union for International Cancer Control²*
World Blind Union*
World Council of Optometry*
World Federation of Hemophilia*
World Federation of Hydrotherapy and Climatotherapy*
World Heart Federation*
World Hepatitis Alliance
World Hypertension League*
World Plumbing Council*
World Stroke Organization*
World Veterinary Association*

* Based on reports of collaboration for the period under review 2009–2011, the Standing Committee on Nongovernmental Organizations recommended the maintenance of official relations of those nongovernmental organizations whose names are followed by an asterisk. The other nongovernmental organizations are the subject of specific decisions or a resolution.

¹ Previously known as The Royal Commonwealth Society for the Blind (Sightsavers International).

² Previously known as the International Union Against Cancer.

ANNEX 6

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

<p>1. Resolution EB130.R3 Monitoring the achievement of the health-related Millennium Development Goals: implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health</p>
<p>2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf) Strategic objective(s): 10 Organization-wide expected result(s): 10.4 and 10.10</p> <p>How would this resolution contribute to the achievement of the Organization-wide expected result(s)? It would support the strengthening of (i) country health information and accountability systems and (ii) global monitoring of results and resources.</p> <p>Does the programme budget already include the products or services requested in this resolution? (Yes/no) Yes, some are included.</p>
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</p> <p>(i) 4 years (covering the period 2012–2015) (ii) Total US\$ 22.0 million (staff US\$ 16.0 million; activities: US\$ 6.0 million)</p> <p>(b) Cost for the biennium 2012–2013 Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000) Total US\$ 11.0 million (staff US\$ 8.0 million; activities: US\$ 3.0 million)</p> <p>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant Headquarters and regional offices</p> <p>Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no) No If "no", indicate how much is not included. US\$ 5.5 million, about 50%.</p> <p>(c) Staffing implications Could the resolution be implemented by existing staff? (Yes/no) Yes If "no" indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.</p>

4. Funding

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

No

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

US\$ 4.0 million; source(s) of funds: many other potential donors are being approached.

1. Resolution EB130.R6 Strengthening noncommunicable disease policies to promote active ageing**2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)**

Strategic objective(s): 4

Organization-wide expected result(s): 4.8

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

The resolution requests the Director-General to provide support to Member States in promoting and facilitating further implementation of commitments made at relevant United Nations conferences and summits on noncommunicable diseases and ageing; and to continue development of a comprehensive global monitoring system for prevention and control of noncommunicable diseases to monitor progress. This is in line with the Organization-wide expected result mentioned above.

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

No

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

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

(i) 3 years (covering the period 2012–2014)

(ii) Total: US\$ 1.49 million (staff US\$ 290 000; activities: US\$ 1.20 million)

(b) Cost for the biennium 2012–2013

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

Total: US\$ 1.09 million (staff US\$ 290 000; activities: US\$ 800 000)

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

Headquarters

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

No

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

US\$ 1.09 million

(c) Staffing implications

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

No

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

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

4. Funding

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

No

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

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

1. Resolution EB130.R7 Follow-up to the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases

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

Strategic objective(s): 3 and 6

Organization-wide expected result(s): 3.3, 6.2 and 6.3

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

It would contribute to achievement of the expected results mentioned above by giving further impetus to the development of a comprehensive global monitoring framework and of recommendations for a set of voluntary global targets for the prevention and control of noncommunicable diseases, in accordance with paragraphs 61 and 62 of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases.

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

Yes.

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

(a) Total cost

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

(i) 2 years (covering the period 2012–2013)

(ii) Total US\$ 2.5 million (staff: US\$ 1.5 million; activities: US\$ 1.0 million)

(b) Cost for the biennium 2012–2013

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

Total US\$ 2.5 million (staff: US\$ 1.5 million; activities: US\$ 1.0 million)

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

At headquarters and in all six regions

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

Yes

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

(c) Staffing implications

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

Yes

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

4. Funding

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

No

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

US\$ 2.0 million; source(s) of funds: voluntary contributions from bilateral donors.

1. Resolution EB130.R8 Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level

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

Strategic objective(s): 3

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

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

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

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

No

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

(a) Total cost

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

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

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

(b) Cost for the biennium 2012–2013

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

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

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

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

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

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

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

(c) Staffing implications

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

Yes

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

4. Funding

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

Yes

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

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

1. Resolution EB130.R9 Elimination of schistosomiasis

2. Linkage to the Programme budget 2012–2013 (see document A64/7

http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf

Strategic objective(s): 1

Organization-wide expected result(s): 1.3

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

Support would be provided to Member States in confirming that they have satisfied the criteria for the elimination of schistosomiasis within their national borders.

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

Yes

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

(a) Total cost

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

(i) 14 years (covering the period 2012–2025)

(ii) Total: US\$ 700 000 (staff: US\$ nil; activities: US\$ 700 000)

(b) Cost for the biennium 2012–2013

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

Total: US\$ 100 000 (staff: US\$ nil; activities: US\$ 100 000)

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

Headquarters

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

Yes

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

(c) Staffing implications

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

Yes

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

4. Funding

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

Yes

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

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

1. Resolution EB130.R10 Poliomyelitis: intensification of the global eradication initiative**2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)**

Strategic objective(s): 1

Organization-wide expected result(s): 1.2

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

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

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

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

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

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

(i) 6 years (covering the period 2013–2018)

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

(b) Cost for the biennium 2012–2013

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

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

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

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

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

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

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

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

(c) Staffing implications

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

Yes.

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

4. Funding

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

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

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

US\$ 596 million; source(s) of funds: earmarked voluntary contributions from WHO Member States, multilateral organizations (including the European Commission and development banks), the private sector (including the Bill & Melinda Gates Foundation and Rotary International).

1. Resolution EB130.R11 Outcome of the World Conference on Social Determinants of Health

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

Strategic objective(s): 7 and 10

Organization-wide expected result(s): 7.1, 7.2, 7.3 and 10.5

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

The resolution would contribute to the achievement of the Organization-wide expected results mentioned above by requesting the Secretariat to scale up action on the social determinants of health, as identified in the Rio Political Declaration on Social Determinants of Health (2011).

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

No

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

(a) Total cost

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

(i) 6 years (covering the period 2012–2017)

(ii) Total: US\$ 127.0 million (staff: US\$ 83.0 million; activities: US\$ 44.0 million)

(b) Cost for the biennium 2012–2013

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

Total: US\$ 42.0 million (staff: US\$ 28.0 million; activities: US\$ 14.0 million)

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

Headquarters: US\$ 16.0 million; regional offices: US\$ 10.0 million; country offices: US\$ 16.0 million

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

No

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

US\$ 8.3 million

(c) Staffing implications

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

No

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

In order to implement the resolution, six staff at grade P.4 and six at grade G.4 would be required at the country and regional levels, and one staff member at grade P.4 would be needed at headquarters.

4. Funding

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

No

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

US\$ 29.0 million; source(s) of funds: voluntary contributions from countries, private donors and multilateral organizations.

1. Resolution EB130.R12 World Immunization Week**2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)**

Strategic objective(s): 1

Organization-wide expected result(s): 1.1

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

Immunization Weeks help to: (i) raise global and local awareness of the benefits of vaccination; (ii) increase the population’s acceptance of, and demand for, immunization services; (iii) enhance political commitment; (iv) provide an additional opportunity to deliver vaccines to people, and, consequently, contribute to improving vaccine coverage.

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

Yes

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

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

(i) Implementation would be on a continuing basis, subject to review by the governing bodies.

(ii) Total additional cost: US\$ 150 000 per annum (staff US\$ 30 000; activities: US\$ 120 000).

Note: All WHO regions have adopted their own resolutions on Regional Immunization Weeks; four regions have been implementing Immunization Weeks for a number of years, with the African and South-East Asia regions joining them in 2012. Consequently, the cost of Regional Immunization Weeks has already been planned for and funded, and the increase in cost due to the introduction of the World Immunization Week would be minimal and would simply reflect some additional staff time at the global level needed for coordination, additional media and communication materials, and a small coordination meeting.

(b) Cost for the biennium 2012–2013

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

Total additional cost: US\$ 300 000 (staff US\$ 60 000; activities: US\$ 240 000)

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

Headquarters

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

Yes

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

(c) Staffing implications

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

Yes

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

4. Funding

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

Yes

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

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

1. Resolution EB130.R13 Substandard/spurious/false-labelled/falsified/counterfeit medical products

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

Strategic objective(s): 11

Organization-wide expected result(s): 11.1 and 11.2

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

It responds to the strategic approach outlined in expected result 11.1 regarding “substandard/spurious/false-labelled/falsified/counterfeit medical products”.

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

No

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

(a) Total cost

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

- (i) 3 years (covering the period 2012–2015) subject to the decision of the Health Assembly.
- (ii) Total: between US\$ 3.56 million and US\$ 4.84 million (staff: between US\$ 2.72 million and US\$ 4.00 million; activities: US\$ 840 000). Conservative estimation based on a single annual meeting of the Member State mechanism. This only covers the cost of activities for one meeting as the terms of reference still need to be confirmed.

(b) Cost for the biennium 2012–2013

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

Total: between US\$ 2.37 million and US\$ 3.23 million (staff: between US\$ 1.81 million and US\$ 2.67 million; activities US\$ 560 000).

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

Headquarters

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

No

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

Between US\$ 2.37 million and US\$ 3.23 million

(c) Staffing implications

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

No

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

Two staff members in the professional and higher categories (grades P.4 and P.5) together with one staff member in the general services category (grade G.5).

4. Funding

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

No

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

Between US\$ 2.37 million and US\$ 3.23 million; source(s) of funds:

It is likely that seed money will be needed in the form of voluntary contributions from interested Member States, as technical activities are currently not defined with enough detail to address donors. Also, the project falls outside the current scope of donors in the medicines area.

1. Resolution EB130.R14 WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies

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

Strategic objective(s): 5

Organization-wide expected result(s): 5.1 and 5.7

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

The resolution would support WHO in fulfilling its role as (i) lead agency of the health cluster in humanitarian emergencies and (ii) lead agency for the Inter-Agency Standing Committee Global Health Cluster. It would also strengthen WHO's new cross-organizational approach to emergency response. The resolution contains a call to the Director-General to put in place the necessary WHO policies, guidelines, adequate management structures and processes, required for effective and successful humanitarian action at the country level, as well as the organizational capacity and resources to best fulfil its role as the Global Health Cluster lead agency. Thus, implementation would enhance the achievement of Organization-wide expected result 5.7 by giving direction, structure and impetus to the Organization's work to lead a coordinated health-sector response and recovery in humanitarian emergencies.

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

Yes

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

(a) Total cost

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

(i) The key period for this resolution would be the biennium 2012–2013. During this period, WHO would implement, evaluate and refine its new institutional approach. After 2013, it is expected that the underlying principles of this resolution would continue to guide WHO's work in emergencies.

(ii) Total first year: US\$ 29.5 million (staff: US\$ 23.6 million; activities: US\$ 5.9 million); total subsequent years: US\$ 42.5 million (staff: US\$ 34.0 million; activities: US\$ 8.5 million).

The implementation of this resolution over the first year is expected to be gradual at the regional and country levels and is therefore estimated at 70% of the cost of implementation in the last year of the biennium.¹

(b) Cost for the biennium 2012–2013

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

Total: US\$ 72.0 million (staff: US\$ 57.6 million; activities: US\$ 14.4 million)

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

This resolution would be implemented across the Organization. WHO's country-level efforts would be supported by the relevant regional offices and by headquarters (US\$ 32.0 million at headquarters; US\$ 13.5 million in the regional offices; and US\$ 26.5 million in key country offices, with a focus on high-risk countries in the African and Eastern Mediterranean regions).¹

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

Yes

If "no", indicate how much is not included.

(c) Staffing implications

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

No

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

The total number of core staff would be similar to that of the biennium 2010–2011; however, the staff concerned would have different skill sets and there would be a different geographic distribution of posts, following the downsizing at headquarters in 2011 and the anticipated increase in staffing at the regional and country levels. At the country office level it is envisaged

¹ The figures given do not include the additional resources that would be mobilized for specific emergencies.

that the current complement of 35 core staff in the professional and higher categories would double to 70, with an emphasis on countries in the African and Eastern Mediterranean regions. Staff increases would also be required at the regional office level to ensure that the necessary competencies were present for overseeing and for fulfilling a backstopping role for the country offices. At the regional office level, it is likely that the current complement of 24 core professional staff would need to increase to 36, with an emphasis on the regional offices for Africa and the Eastern Mediterranean. Headquarters would require no additional staff as the relevant department was restructured and significantly downsized in 2011.

4. Funding

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

No

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

US\$ 44.0 million; source(s) of funds: assessed contributions, voluntary contributions and programme monitoring and reporting funds. Response and recovery activities would be funded by any funding for outbreak and crisis response received against the consolidated and flash appeals for specific emergencies.

1. Resolution EB130.R15 Amendments to the Staff Rules

Resolution EB130.R16 Salaries of staff in ungraded posts and of the Director-General

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

Strategic objective(s): 13

Organization-wide expected result(s): 13.3

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

The amendments outlined in the Secretariat’s report¹ support the Organization’s human resources policies since they aim to ensure that WHO’s compensation system complies with the decisions that are expected to be taken by the United Nations General Assembly. The amendments represent the implementation of recommendations contained in the report of the International Civil Service Commission, which has been submitted to the General Assembly for consideration at its sixty-sixth session.

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

Yes

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

(a) Total cost

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

(i) Two years (covering the period 2012–2013)

(ii) Total: US\$ 630 000 (staff: US\$ 630 000; activities: US\$ nil)

(b) Cost for the biennium 2012–2013

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

Total: US\$ 630 000 (staff: US\$ 630 000; activities: US\$ nil)

Indicate at which levels of the Organization the costs would be incurred, identifying

¹ Document EB130/28. This report contained two draft resolutions, which were adopted as resolution EB130.R15 and resolution EB130.R16, respectively.

Headquarters: US\$ 1.07 million (staff); US\$ 1.20 million (activities)

Regional offices/country offices: US\$ 3.71 million (staff); US\$ 2.30 million (activities).

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

No

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

Although the implementation of the comprehensive implementation plan on maternal, infant and young child nutrition is already included in the approved Programme budget, the resolution calls for further action by the Secretariat in two areas:

- (a) the development of guidance on multisectoral policy measures on nutrition;
- (b) the development of guidelines on the marketing of complementary foods.

The cost of such additional activities would amount to approximately US\$ 600 000, which would require an increase in the approved Programme budget. Otherwise, it might be possible to accommodate the cost if other activities were suppressed or delayed, such as the work on nutrition in emergencies.

(c) Staffing implications

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

No

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

Although most of the Secretariat activities requested by the resolution can be implemented by current staff, the provision of support to Member States in strengthening national health and development policies that include proven nutrition actions would require additional human resources in the regional offices. In particular, two additional staff members in the professional and higher categories would be needed in the Regional Office for Africa (one at grade P.4 and one at grade P.3) and one additional staff member per region in the regional offices for the Americas, South-East Asia and the Western Pacific (all at grade P.3). These extra staff members are not included in the above costing. They would be sought through reprogramming in regional and country offices.

4. Funding

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

No

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

For the biennium 2012–2013, US\$ 4.60 million are available for the implementation of the resolution, as part of currently available resources. Additional funding of US\$ 3.68 million would need to be secured through active fundraising.