



WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD

136TH SESSION

GENEVA, 26 JANUARY–3 FEBRUARY 2015

RESOLUTIONS AND DECISIONS

ANNEXES

GENEVA
2015



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ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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

The designations used and the presentation of the material in this volume do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Where the designation “country or area” appears in the headings of tables, it covers countries, territories, cities or areas.

PREFACE

The 136th session of the Executive Board was held at WHO headquarters, Geneva, from 26 January to 3 February 2015. 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 EB136/2015/REC/2.

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 - 6.4 Follow-up to the 2014 high-level meeting of the United Nations General Assembly to undertake a comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases

¹ As adopted by the Board at its first meeting (26 January 2015).

² **EB133(1) Deletion of agenda item**

The Executive Board decided:

- (1) to delete item 6.3 from its provisional agenda;
- (2) to request the Director-General to hold informal consultations with Member States from all regions with a view to reaching consensus on the title and content of that item;
- (3) to include an item in the draft provisional agenda of the Executive Board at its 134th session, with no title and a footnote referring to the present decision, on the understanding that the final title and content of the item will reflect the outcome of the informal consultations by the Director-General.

(Second meeting, 29 May 2013)

The informal consultations have not been concluded. The Director-General will provide an update to Executive Board members.

- 6.5 Global status report on violence and health
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EB136/2	Report by the Director-General to the Executive Board at its 136th session
EB136/3	Report of the Programme, Budget and Administration Committee of the Executive Board
EB136/4	Report of the regional committees to the Executive Board
EB136/5	Framework of engagement with non-State actors ²
EB136/6	Method of work of the governing bodies
EB136/7	WHO reform: overview of reform implementation
EB136/8	Outcome of the Second International Conference on Nutrition
EB136/9	Maternal, infant and young child nutrition: development of the core set of indicators
EB136/10	Update on the Commission on Ending Childhood Obesity
EB136/11	Follow-up to the 2014 high-level meeting of the United Nations General Assembly to undertake a comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases ³
EB136/11 Add.1	Follow-up to the 2014 high-level meeting of the United Nations General Assembly to undertake a comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases Proposed work plan for the global coordination mechanism on the prevention and control of noncommunicable diseases covering the period 2016–2017

¹ See page ix.

² See Annex 7.

³ See Annex 6.

EB136/12 and EB136/12 Corr.1	Global status report on violence and health
EB136/13	Global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications ¹
EB136/14	Monitoring of the achievement of the health-related Millennium Development Goals
EB136/15	Health and the environment: addressing the health impact of air pollution
EB136/16	Health and the environment Climate and health: outcome of the WHO Conference on Health and Climate
EB136/17	Adolescent health
EB136/18	Women and health: 20 years of the Beijing Declaration and Platform for Action
EB136/19	Antimicrobial resistance Summary report on progress made in implementing resolution WHA67.25 on antimicrobial resistance
EB136/20	Antimicrobial resistance Draft global action plan on antimicrobial resistance
EB136/21	Poliomyelitis
EB136/21 Add.1	Report on financial and administrative implications for the Secretariat of decisions proposed for adoption by the Executive Board or Health Assembly
EB136/22	Implementation of the International Health Regulations (2005) Responding to public health emergencies ¹
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¹ See Annex 7.

² See Annexes 1 and 7.

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EB136/27	Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage ¹
EB136/28	WHO Global Code of Practice on the International Recruitment of Health Personnel
EB136/29	Substandard/spurious/falsely-labelled/falsified/counterfeit medical products
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EB136/39	Real estate: update on the Geneva buildings renovation strategy
EB136/40	Reports of committees of the Executive Board Standing Committee on Nongovernmental Organizations ³

¹ See Annex 7.

² See Annexes 4 and 7.

³ See Annex 2.

EB136/41	Awards ¹
EB136/42	Provisional agenda of the Sixty-eighth World Health Assembly and date, place and draft provisional agenda of the 137th session of the Executive Board
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EB136/44	Appointment of the Regional Director for Europe
EB136/45	Human resources: update
EB136/46	Report of the International Civil Service Commission
EB136/47	Amendments to the Staff Regulations and Staff Rules ²
EB136/47 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly ³
EB136/48 Rev.1	Reports of advisory bodies: Expert committees and study groups
EB136/48 Add.1	Reports of advisory bodies: Expert committees and study groups – expert advisory panels and committees and their membership
EB136/49	Ensuring WHO's capacity to prepare for and respond to future large-scale and sustained outbreaks and emergencies

Information documents

EB136/INF./1	Statement by the representative of the WHO staff associations
EB136/INF./2	Framework of engagement with non-State actors: information on regional committee debates
EB136/INF./3	Process for developing the Proposed programme budget 2016–2017
EB136/INF./4	Fast-tracking the development and prospective roll-out of vaccines, therapies and diagnostics in response to Ebola virus disease

¹ See Annex 5.

² See Annex 3.

³ See Annex 7.

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EB136/INF./5	Building resilient health systems in Ebola-affected countries
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EB136/INF./7	IHR and Ebola
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EB136/INF./9	Human resources: update Note on the status of PAHO

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EB136/DIV./1 Rev.1	List of members and other participants
EB136/DIV./2	Preliminary daily timetable
EB136/DIV./3	Decisions and list of resolutions
EB136/DIV./4	List of documents

RESOLUTIONS

EB136.R1 Global technical strategy and targets for malaria 2016–2030

The Executive Board,

Having considered the report on malaria: draft global technical strategy: post 2015,¹

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

The Sixty-eighth World Health Assembly,

Recalling resolutions WHA58.2 on malaria control, WHA60.18 on malaria, including proposal for establishment of World Malaria Day and WHA64.17 on malaria, and United Nations General Assembly resolutions 65/273, 66/289, 67/299 and 68/308 on consolidating gains and accelerating efforts to control and eliminate malaria in developing countries, particularly in Africa, by 2015;

Acknowledging the progress made towards the achievement of Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases), and towards the targets set by the Health Assembly in resolution WHA58.2;

Recognizing that these gains, when complemented by further investments in new cost-effective interventions, provide an opportunity to further reduce the high burden of malaria and accelerate progress towards elimination;

Noting that approximately 200 million cases of malaria are estimated to have occurred in 2013; that the disease led to more than 580 000 deaths in 2013, mostly in children under five years of age in Africa, and imposes a significant burden on households, communities and health services in high-burden countries; and that the number of cases and deaths will increase unless efforts to reduce the disease burden are intensified;

Recognizing that malaria interventions are highly cost-effective, yet there is a need to urgently address and overcome the barriers that hinder universal access of at-risk populations to vector-control measures, preventive therapies, quality-assured diagnostic testing and treatment for malaria;

Recognizing also that malaria-related morbidity and mortality throughout the world can be substantially reduced with political commitment and commensurate resources if the public is educated and sensitized about malaria and appropriate health services are made available, particularly in countries where the disease is endemic;

¹ Document EB136/23.

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

Deeply concerned by the regional and global health threat posed by the emergence and spread of insecticide and drug resistance, including artemisinin resistance, and the systemic challenges impeding further progress, including weak health and disease surveillance systems in many affected countries;

Cognizant of the grave economic and social burden that malaria inflicts on the most vulnerable and poorest communities in countries in which malaria is endemic, and of the disproportionate burden that is borne by countries in sub-Saharan Africa, and high-risk groups, including migrant and mobile populations;

Cognizant also that a reduction in the malaria burden can improve social conditions and lift communities out of poverty, and that it has a positive economic and social impact;

Acknowledging that recent successes in malaria prevention and control are fragile and that further progress depends on action within and beyond the health sector, which requires long-term political and financial commitments, strong regional collaboration, the strengthening of health systems, and investments in innovation and research;

Recognizing that in the interconnected and interdependent world, no country is risk-free in respect of malaria, including countries that have recently eliminated the disease and countries that are non-endemic for malaria,

1. ADOPTS the global technical strategy for malaria 2016–2030, with:
 - (1) its bold vision of a world free of malaria, and its targets to reduce malaria incidence and mortality rates globally by at least 90% by 2030, to eliminate the disease in at least 35 new countries, and to prevent its re-establishment in countries that were free of malaria in 2015;
 - (2) its associated milestones for 2020 and 2025;
 - (3) its five principles addressing: acceleration of efforts towards elimination; country ownership and leadership, with the involvement and participation of communities; improved surveillance, monitoring and evaluation; equity in access to health services; and innovation in tools and implementation approaches;
 - (4) its three pillars of: ensuring universal access to malaria prevention, diagnosis and treatment; accelerating efforts towards elimination and attainment of malaria-free status; and transforming malaria surveillance into a core intervention;
 - (5) its two supporting elements of: harnessing innovation and expanding research; and strengthening the enabling environment;
2. URGES Member States:¹
 - (1) to update national malaria strategies and operational plans consistent with the recommendations of the global technical strategy for malaria 2016–2030;

¹ And, where applicable, regional economic integration organizations.

-
- (2) to intensify national and regional efforts to reduce malaria morbidity and mortality in high-burden countries and accelerate progress towards elimination, and, where appropriate, maintain malaria-free status;
 - (3) to strengthen health systems, including both the public and private sectors, and devise plans for achieving and maintaining universal access on the part of at-risk populations to WHO-recommended core malaria interventions;
 - (4) to intensify national, cross-border, regional and subregional efforts to address the threat posed by rising insecticide and drug resistance, including artemisinin resistance;
 - (5) to promote multisectoral collaboration, educational programmes, and community involvement in order to strengthen efforts for malaria control and elimination;
 - (6) to establish and strengthen, as appropriate, national malaria surveillance and response systems in order to improve the quality of data and the effectiveness and efficiency of national malaria responses;
 - (7) to promote basic and applied research into malaria and accelerate the rapid development and adoption of good-quality and cost-effective new tools, in particular vaccines, medicines, diagnostics, surveillance, insecticides and vector control tools to prevent and control malaria, and to collaborate on new approaches;
 - (8) to strengthen human resource capacity and infrastructure to improve the effectiveness, efficiency and sustainability of malaria responses, while ensuring integration and synergies with the wider health system;
 - (9) to consider the financial implications of this resolution in the broader context of health sector development, and increase national, regional and international funding for malaria interventions, and for cross-border and regional initiatives;
3. INVITES international, regional and national partners from within and beyond the health sector, in particular those in the Roll Back Malaria Partnership, to engage in, and support, the implementation of the global technical strategy for malaria 2016–2030;
 4. CALLS UPON WHO's international partners, including intergovernmental and international organizations, financing bodies, academic and research institutions, civil society and the private sector to support Member States,¹ as appropriate:
 - (1) to mobilize sufficient and predictable funding to enable an accelerated reduction of the malaria burden, particularly in high-burden countries, and progress towards elimination, in line with the milestones and targets proposed in the global technical strategy for malaria 2016–2030;
 - (2) to support knowledge generation, research and innovation to speed up the development of new vector-control tools, diagnostics, medicines and vaccines, and of new surveillance, data management, operational delivery and implementation solutions;
 - (3) to harmonize the provision of support to countries for adopting and implementing WHO-recommended policies and strategies;

¹ And, where applicable, regional economic integration organizations.

5. REQUESTS the Director-General:

- (1) to provide technical support and guidance to Member States¹ for the implementation, national adaptation and operationalization of the global technical strategy for malaria 2016–2030;
- (2) to update technical guidance on malaria prevention, care and elimination regularly, as new evidence is gathered and new innovative tools and approaches become available;
- (3) to monitor the implementation of the global technical strategy for malaria 2016–2030 and evaluate its impact in terms of progress towards set milestones and targets;
- (4) to strengthen the Secretariat's capacities to enable it to increase its technical support to Member States,¹ in order to meet the global milestones and targets;
- (5) to ensure that all relevant parts of the Organization, at headquarters, regional and country levels, are actively engaged and coordinated in promoting and implementing the global technical strategy for malaria 2016–2030;
- (6) to report on the progress achieved to the Seventieth and Seventy-second World Health Assemblies, and at regular intervals thereafter, through the Executive Board.

(Second meeting, 26 January 2015)

EB136.R2 Appointment of the Regional Director for Africa

The Executive Board,

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

Considering also the nomination made by the Regional Committee for Africa at its sixty-fourth session,

1. APPOINTS Dr Matshidiso Rebecca Moeti as Regional Director for Africa as from 1 February 2015;
2. AUTHORIZES the Director-General to issue to Dr Matshidiso Rebecca Moeti a contract for a period of five years from 1 February 2015, subject to the provisions of the Staff Regulations and Staff Rules.

(Third meeting, 27 January 2015)

EB136.R3 Expression of appreciation to Dr Luis Gomes Sambo

The Executive Board,

Desiring, on the occasion of the retirement of Dr Luis Gomes Sambo as Regional Director for Africa, to express its appreciation of his services to the World Health Organization;

¹ And, where applicable, regional economic integration organizations.

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

Recalling resolution AFR/RC64/R2, adopted by the Regional Committee for Africa, which designates Dr Luis Gomes Sambo as Regional Director Emeritus,

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

(Third meeting, 27 January 2015)

EB136.R4 Appointment of the Regional Director for Europe

The Executive Board,

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

Considering also the nomination made by the Regional Committee for Europe at its sixty-fourth session,

1. REAPPOINTS Ms Zsuzsanna Jakab as Regional Director for Europe as from 1 February 2015;
2. AUTHORIZES the Director-General to issue to Ms Zsuzsanna Jakab a contract for a period of five years from 1 February 2015, subject to the provisions of the Staff Regulations and Staff Rules.

(Third meeting, 27 January 2015)

EB136.R5 Yellow fever risk mapping and recommended vaccination for travellers

The Executive Board,

Having considered the report on Implementation of the International Health Regulations (2005),¹

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

The Sixty-eighth World Health Assembly,

Recalling the adoption by the Sixty-seventh World Health Assembly of the updated Annex 7 of the International Health Regulations (2005);³ and the report of the Strategic

¹ See document EB136/22.

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

³ See resolution WHA67.13 and WHA67/2014/REC/1, Annex 5.

Advisory Group of Experts on immunization,¹ which concluded that a single dose of yellow fever vaccine is sufficient to confer sustained immunity and life-long protection against yellow fever, that a booster dose of yellow fever vaccine is not needed, and that the validity of a certificate of vaccination against yellow fever shall extend for the life of the person vaccinated;

Highlighting the fact that States Parties may immediately apply these changes even though Annex 7 of the International Health Regulations (2005), as amended, is expected to enter into force in June 2016, in accordance with Article 59 of the Regulations;

Noting that, for the purposes of Annex 7 of the International Health Regulations (2005), vaccination against yellow fever may be required of any traveller leaving an area where the Organization has determined that a risk of yellow fever transmission is present,

1. URGES Members States:

(1) during the interim period until June 2016, to inform WHO if they voluntarily accept to extend the validity of a certificate of vaccination against yellow fever for the life of the person vaccinated;

(2) to comply with the WHO recommendation for the definition of areas at risk of yellow fever and of the yellow fever vaccination recommendations for travellers;

2. REQUESTS the Director-General:

(1) to publish, and update in real time, an online list of countries accepting a certificate of vaccination against yellow fever for the life of the person vaccinated;

(2) to establish a formal scientific and technical advisory group on geographical yellow fever risk mapping, with the participation of countries with areas at risk of yellow fever, to: (i) maintain up-to-date yellow fever risk mapping; and (ii) provide guidance on yellow fever vaccination for travellers in ways that facilitate international travel.

(Eighth meeting, 29 January 2015)

EB136.R6 The recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation²

The Executive Board,

Having considered the report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation,³

¹ Meeting of the Strategic Advisory Group of Experts on immunization, April 2013 – conclusions and recommendations. Weekly Epidemiological Record, 2013; 88(20): 201–216 (<http://www.who.int/wer/2013/wer8820.pdf?ua=1>, accessed 4 May 2015).

² See Annex 1.

³ Document EB136/22 Add.1.

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

The Sixty-eighth World Health Assembly,

Reminding Member States of their rights and obligations under the International Health Regulations (2005) and their responsibility to the international community;

Recalling the final report of the Review Committee on the Functioning of the International Health Regulations (2005) and on Pandemic Influenza A (H1N1) 2009 transmitted by the Director-General to the Sixty-fourth World Health Assembly;²

Recognizing the establishment of a review committee as required under Articles 5 and 13 of the International Health Regulations (2005) and as provided for in Chapter III of Part IX of the said Regulations;

Commending the successful conclusion of the work of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation, the leadership of its chair, the dedication of its distinguished members, and the submission of its report to the Director-General for transmittal to the Sixty-eighth World Health Assembly,

1. URGES Member States to support the implementation of the recommendations contained in the report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation;

2. REQUESTS the Director-General:

(1) to present an update to the Sixty-ninth World Health Assembly, through the Executive Board, on progress made in taking forward the recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation;

(2) to provide technical support to Member States in implementing the recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation.

(Eighth meeting, 29 January 2015)

EB136.R7 Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage

The Executive Board,

Having considered the report on strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage,³

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

² Document A64/10.

³ Document EB136/27.

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

The Sixty-eighth World Health Assembly,

Recognizing that each year more than 234 million surgical procedures are performed globally for a wide range of common conditions requiring surgical care, affecting all age groups – including obstructed labour, birth defects, cataracts, cancer, diabetes, acute abdominal conditions, burns and injuries from domestic and industrial and road accidents – and that conditions for which surgery is one of the primary clinical solutions are expected to become increasingly common in the coming years;

Noting that many surgically treatable diseases are among the top 15 causes of physical disability worldwide and that 11% of the world's burden of disease stems from conditions that could be treated successfully through surgery, with low- and middle-income countries being the most affected;

Recognizing that each year more than 100 million people sustain injuries globally, more than five million people die from violence and injury, and that 90% of the global burden of violence and injury mortality occurs in low- and middle-income countries;

Noting that more than 289 000 women die every year in childbirth and that approximately a quarter of maternal deaths, as well as infant deaths and disabilities that result from obstructed labour, haemorrhage and infection, could be avoided if safe surgery and anaesthesia were universally available;

Noting also that the sustainable provision of emergency and essential surgical care and anaesthesia is a critical part of integrated primary health care, lowers mortality and disability, reduces deaths resulting from birth defects, and prevents other adverse health outcomes arising from the burden of injuries and noncommunicable diseases;

Noting further the relevance of emergency and essential surgical care and anaesthesia in achieving the Millennium Development Goals and for attending to the unfinished business post-2015, including universal health coverage;

Recognizing the importance of timely referral and the existence of standards and protocols, such as those defined in the WHO Integrated Management for Emergency and Essential Surgical Care, in the continuum of care, and recalling that resolution WHA55.18 on quality of care: patient safety urges Member States to establish and strengthen science-based systems, necessary for improving patients' safety and the quality of health care, including the monitoring of drugs, medical equipment and technology;

Recognizing also that emergency and essential surgical care and anaesthesia are a neglected but efficacious and cost-effective addition to the basic package of health services and that strengthening emergency and essential surgical capacity together with anaesthesia, particularly at the first-level referral hospitals, is a highly cost-efficient solution to the global burden of disease;

Noting the importance of analgesia in surgery and anaesthesia, and that a large proportion of the global population has limited access to opioid analgesics for pain relief, and patients with

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

moderate and severe pain often do not receive the treatment they need, that 5500 million people (83% of the world's population) live in countries with low to non-existent access, that 250 million (4%) have moderate access, that 460 million (7%) have adequate access, and that insufficient data are available for 430 million people (7%);

Recognizing that balanced policies and regulations for improving access to controlled medicines, while preventing their misuse, have been successfully implemented in a number of countries;

Emphasizing the need for Member States,¹ with the support of the Secretariat, the United Nations Office on Drugs and Crime, and the International Narcotics Control Board, to ensure that efforts to prevent diversion and abuse of narcotic drugs and psychotropic substances under international control, pursuant to the United Nations international drug control conventions, do not result in inappropriate regulatory barriers to medical access to such medicines;²

Recalling that resolution WHA56.24 on implementing the recommendations of the *World report on violence and health* requested the Director-General to provide technical support for strengthening trauma and care services to survivors or victims of violence, and that resolution WHA57.10 on road safety and health recommended Member States to strengthen emergency and rehabilitation services for victims of road-traffic injuries;

Recognizing that 15% of the world's population live with a disability, and recalling that resolution WHA58.23 on disability, including prevention, management and rehabilitation urged Member States to promote early intervention and take necessary steps for the reduction of risk factors contributing to disabilities, especially during pregnancy and for children, and to put into practice the most effective actions to prevent disabilities, which include timely and effective surgery where required;

Aware of the critical importance of health system strengthening for providing access to quality, safe, effective and affordable emergency and essential surgical care and anaesthesia, and recalling resolution WHA60.22 on health systems: emergency-care systems, which recognized that improved organization and planning for the provision of trauma and emergency care, including surgery, is an essential part of integrated health-care delivery;

Recalling also resolution WHA64.6 on health workforce strengthening, which urges Member States to prioritize, in the context of global economic conditions, public sector spending on health, as appropriate, to ensure that sufficient financial resources are available for the implementation of policies and strategies to scale up and retain the health workforce, particularly in developing countries, and to recognize it as an investment in the health of the population that contributes to social and economic development, including access to emergency and essential surgical and anaesthesia services;

Recalling further resolution WHA66.10 on the follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, which calls for action to prevent and control cardiovascular diseases, cancer, diabetes and chronic respiratory diseases, and noting the important role of surgical care for diagnosis, treatment and cure of a significant portion of these diseases;

¹ And, where applicable, regional economic integration organizations.

² See resolution WHA67.19.

Aware of the critical importance of access to and responsible use of effective antimicrobial agents for safe surgery, and recalling resolution WHA67.25 on antimicrobial resistance, which urges Member States to take urgent action to combat antimicrobial resistance;

Recalling resolution WHA67.19 on strengthening of palliative care as a component of comprehensive care throughout the life course, which urges Member States¹ to promote collaborative action to ensure adequate supply of essential medicines in palliative care, and requests the Director-General to explore ways to increase the availability and accessibility of medicines used in palliative care through consultation with Member States relevant networks and civil society, as well as other international stakeholders, as appropriate;

Acknowledging the work already done by WHO Global Initiative for Emergency and Essential Surgical Care in the WHO programme for emergency and essential surgical care, the World Alliance for Patient Safety and the Alliance's second global patient safety challenge: safe surgery saves lives;

Concerned that inadequate investment in the infrastructure of health systems, inadequate training of the surgical care health workforce, and the absence of a stable supply of surgical equipment and necessities in many countries impede progress in improving delivery of emergency and essential surgical care and anaesthesia;

Recognizing that relevant, meaningful and reliable measures of safe emergency and essential surgery and anaesthesia are needed for assessment and monitoring, and to foster political and public support;

Acknowledging that many countries are unable to meet the threshold of 2.28 skilled health professionals per 1000 population, and many surgical procedures, including basic suturing, episiotomies and draining of abscesses, can be successfully completed by other trained health care workers through task-sharing at the district and subdistrict levels;²

Considering that additional efforts are required globally to strengthen the provision of emergency and essential surgical care and anaesthesia so as to ensure timely and effective delivery to those who need such care in the overall context of the health system, and related health and health-promotion initiatives,

1. URGES Member States:¹

(1) to identify and prioritize a core set of emergency and essential surgery and anaesthesia services at the primary health care and first-referral hospital level, and to develop methods and financing systems for making quality, safe, effective and affordable emergency and essential surgical care and anaesthesia services accessible to all who need them, including promoting timely referral and more effective use of the health care workforce through task-sharing, as appropriate, as part of an integrated surgical care network in order to achieve universal health coverage;

(2) to integrate emergency and essential surgical care and anaesthesia in primary health care facilities and first-referral hospitals, and to promote emergency and essential

¹ And, where applicable, regional economic integration organizations.

² The world health report 2006. Working Together for Health. Geneva: World Health Organization; 2006.

surgery and anaesthesia capacity as components integral to achieving universal health coverage;

(3) to promote the provision of emergency and essential surgical care and anaesthesia and ensure that health ministries take a lead role in, and intersectoral coordination mechanisms, including among all health care providers, are in place for, reviewing and strengthening the provision of such care;

(4) to promote access to essential medicines, including controlled medicines, antibiotics, medical devices and diagnostics used in anaesthesiology and surgery that are of quality, safe, efficacious, affordable, and are used responsibly and appropriately and in line with WHO guidelines;

(5) to carry out regular monitoring and evaluation of the emergency and essential surgical care and anaesthesia capacity of health care facilities in order to identify unmet infrastructural needs, human resource needs, training and supply needs;

(6) to collect and compile data on number, type and indications of surgical procedures performed, referrals and perioperative mortality in their respective countries, and to share such data as appropriate;

(7) to strengthen infection prevention and control as a critical element of ensuring quality and safety of emergency and essential surgical care and anaesthesia;

(8) to develop and implement surgical care and anaesthesia policies to assure minimum standards for a skilled workforce, adequate equipment, infrastructure and supplies, and documenting, monitoring, and evaluation of access to and quality of services, to be embedded in programmes and legislation based on current knowledge and considerations promoting the right to the enjoyment of the highest attainable standard of health;

(9) to ensure that appropriate core competencies are part of relevant health curricula, training and education of students from various relevant disciplines such as medical, nursing, midwifery, and other surgical care providers, as well as continuing education for professionals involved in provision of surgical care and anaesthesia;

2. REQUESTS the Director-General:

(1) to foster multisectoral networks and partnerships, multidisciplinary policies and action plans, and support national, regional and global efforts to develop science-based approaches to prevention, screening, and implementation of emergency and essential surgical care and anaesthesia and to enhance teaching and training programmes;

(2) to facilitate collaboration among Member States¹ to share and exchange information, skills and technology essential to strengthening surgery and anaesthesia services;

(3) to raise awareness of cost-effective options to reduce morbidity, mortality and prevent or treat disability and deformity through improved organization and planning of provision of anaesthesia and surgical care that is appropriate for resource-constrained

¹ And, where applicable, regional economic integration organizations.

settings, and continue to organize regular expert meetings to further technical exchange and build capacity in this area;

(4) to establish mechanisms to collect emergency and essential surgical and anaesthesia case log data in order to increase understanding of unmet needs and improve the global capacity for surgery and anaesthesia in the context of universal health coverage;

(5) to devise relevant, meaningful and reliable measures of access to and safety of emergency and essential surgery and anaesthesia, and make available a means of performing risk adjustment of indicators such as the perioperative mortality rate, and reporting and benchmarking of these measures;

(6) to collect, assess and report related cost data on the delivery of emergency and essential surgical care and anaesthesia, as well as the economic impact of their availability;

(7) to support Member States¹ in the development and implementation of policies and regulations for ensuring access to quality, safe, efficacious and affordable-essential medicines, including controlled medicines for pain management, medical devices and diagnostics that are used in emergency and essential surgical care and anaesthesia;

(8) to continue, through WHO's access to controlled medicines programme, to support Member States in reviewing and improving national legislation and policies with the objective of ensuring a balance between the prevention of misuse, diversion and trafficking of controlled substances and appropriate access to controlled medicines, in line with United Nations international drug control conventions;

(9) to work with the International Narcotics Control Board, the United Nations Office on Drugs and Crime, health ministries and other relevant authorities at global, regional and national levels in order to promote the availability and balanced control of controlled medicines for essential and emergency surgical care and anaesthesia;

(10) to further cooperate with the International Narcotics Control Board to support Member States¹ in establishing accurate estimates in order to enable the availability of medicines for emergency and essential and surgical care and anaesthesia, including through better implementation of the guidance on estimating requirements for substances under international control;

(11) to support Member States¹ to devise policies and strategies that enhance the skills of the appropriate health workforce for emergency and essential surgical care and anaesthesia, especially at primary health care and first-referral hospital level;

(12) to set aside adequate resources for the Secretariat, in line with the Proposed programme budget 2016–2017 and the Twelfth General Programme of Work, 2014–2019 for strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage;

(13) to work with Member States and other relevant partners to design strategies that provide support to Member States for mobilizing adequate resources to achieve the

¹ And, where applicable, regional economic integration organizations.

objectives of strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage;

(14) to report back to the Seventieth World Health Assembly in 2017 on progress in the implementation of this resolution.

(Eighth meeting, 29 January 2015)

EB136.R8 Global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications

The Executive Board,

Having considered the report on the global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications,¹

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

The Sixty-eighth World Health Assembly,

Considering resolution WHA66.8, in which the Health Assembly adopted the comprehensive mental health action plan 2013–2020, and resolution WHA67.22 on access to essential medicines;

Acknowledging United Nations General Assembly resolution 68/269 and resolution WHA57.10 on road safety and health, resolution WHA66.12 on neglected tropical diseases, resolution WHA67.10 on the newborn health action plan, resolution WHA67.15 on strengthening the role of the health system in addressing violence, in particular against women and girls, and against children, and the discussions on the control of neurocysticercosis and its association with epilepsy at the Fifty-sixth World Health Assembly;³

Noting the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases,⁴ at which Heads of State and Government recognized that mental and neurological disorders 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;

Considering the Millennium Development Goals, the outcome document of the United Nations Conference on Sustainable Development entitled “The future we want”,⁵ and the report of the Open Working Group on Sustainable Development Goals, established pursuant to United Nations General Assembly resolution 66/288, which proposes Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and target 3.4 (by 2030 reduce by one-third premature

¹ Document EB136/13.

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

³ See document WHA56/2003/REC/3, summary record of the fourth meeting of Committee A.

⁴ United Nations General Assembly resolution 66/2.

⁵ United Nations General Assembly resolution 66/288.

mortality from non-communicable diseases through prevention and treatment, and promote mental health and well-being);¹

Recognizing that epilepsy is one of the most common serious chronic neurological diseases, affecting 50 million people of all ages globally, and that people with epilepsy are often subjected to stigmatization and discrimination because of ignorance, misconceptions and negative attitudes surrounding the disease, and that they face serious difficulties in, for example, education, employment, marriage and reproduction;

Noting with concern that the magnitude of epilepsy affects people of all ages, gender, race and income levels, and further that poor populations and those living in vulnerable situations, in particular in low- and middle-income countries, bear a disproportionate burden, posing a threat to public health and economic and social development;

Cognizant that large differences exist in the level of epilepsy management in different countries, with, for example, the median number of neurologists in low-income countries standing at only 0.03/100 000 population, that the essential antiepileptic medicines are often unavailable, that the treatment gap is estimated to be over 75% in low-income countries and to be substantially wider in rural areas than in urban areas;

Noting that the majority of people with epilepsy can be free from seizures if appropriately treated with cost-effective, affordable antiepileptic medicines;

Recognizing in addition that certain causes of epilepsy can be prevented and that such preventive action can be promoted in the health sector and in sectors outside health;

Aware that in 1997, WHO and two international nongovernmental organizations, the International League Against Epilepsy and the International Bureau for Epilepsy, launched the Global Campaign against Epilepsy – “Out of the Shadows”, and that in 2008 WHO launched its mental health gap action programme, which provided a sound basis for WHO to further lead and coordinate global development work on epilepsy;

Aware also that practice in China and some other low-income countries has proved that country-level coordinated action may be very effective in controlling the disease and improving the quality of life of millions of people with epilepsy at little cost;

Recognizing the remarkable progress made recently in the technology of epilepsy management, from basic research to diagnosis and treatment;

Considering that international governmental organizations, nongovernmental organizations, academic societies and other bodies have recently enhanced their investment in epilepsy management and have undertaken a significant amount of work in collaboration with national governments, such as the International League Against Epilepsy and the International Bureau for Epilepsy, which are in official relations with WHO and have been collaborating with WHO in epilepsy management for several decades;

Recognizing the role of WHO to demonstrate further leadership and coordination and take effective action for epilepsy management, in view of the large public health impact,

¹ Document A/68/970.

1. URGES Member States:¹

(1) to strengthen effective leadership and governance, for policies on general health, mental health and noncommunicable diseases that include consideration of the specific needs of people with epilepsy, and make the financial, human and other resources available that have been identified, as necessary, to implement evidence-based plans and actions;

(2) to introduce and implement, where necessary and in accordance with international human rights norms and standards, national health care plans of action for epilepsy management, aiming to overcome inequalities and inequities in health, social and other related services, paying special attention to people with epilepsy living in conditions of vulnerability, such as those living in poor and remote areas, including by strengthening public health care services, and training local human resources with proper techniques;

(3) to integrate epilepsy management, including health and social care, particularly community-based services, within the context of universal health coverage, including community-based rehabilitation, into primary health care, where appropriate, in order to help to reduce the epilepsy treatment gap, by training non-specialist health care providers to provide them with basic knowledge for the management of epilepsy so that epilepsy can be diagnosed, treated and followed up as much as possible in primary health care settings, as well as by empowering people with epilepsy and their carers for greater use of specified self and home care programmes, by ensuring a strong and functional referral system and by strengthening health information and surveillance systems to routinely collect, report, analyse and evaluate trends on epilepsy management;

(4) to support the establishment and implementation of strategies for the management of epilepsy, particularly to improve accessibility to and promote affordability of safe, effective and quality-assured antiepileptic medicines and include essential antiepileptic medicines into national lists of essential medicines;

(5) to ensure public awareness of and education about epilepsy, in particular in primary and secondary schools, in order to help to reduce the misconceptions, stigmatization and discrimination regarding people with epilepsy and their families that are widespread in many countries and regions;

(6) to promote actions to prevent causes of epilepsy, using evidence-based interventions, within the health sector and in other sectors outside health;

(7) to improve investment in epilepsy research and increase research capacity;

(8) to engage with civil society and other partners in the actions referred to in subparagraphs 1(1) to 1(7) above;

2. INVITES international, regional, national and local partners from within the health sector and beyond to engage in, and support, the implementation of the actions set out in subparagraphs 1(1) to 1(8) above;

¹ And, where applicable, regional economic integration organizations.

3. REQUESTS the Director-General:

(1) to review and evaluate actions relevant to epilepsy that WHO has been leading, coordinating and supporting in order to identify, summarize and integrate the relevant best practices with a view to making this information widely available, especially in low- and middle-income countries;

(2) to develop, in consultation with relevant stakeholders, on the basis of work requested in operative paragraph (1), a set of technical recommendations guiding Member States, in the development and implementation of epilepsy programmes and services, and to provide technical support to Member States in actions for epilepsy management, especially in low- and middle-income countries;

(3) to report back to the Seventy-first World Health Assembly on progress in the implementation of this resolution.

(Fourteenth meeting, 2 February 2015)

EB136.R9 Scale of assessments for 2016–2017

The Executive Board,

Having considered the report on the scale of assessments for 2016–2017,¹

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

The Sixty-eighth World Health Assembly,

Having considered the report of the Director-General,¹

ADOPTS the scale of assessments of Members and Associate Members for the biennium 2016–2017 as set out below.

Members and Associate Members	WHO scale for 2016–2017
	%
Afghanistan	0.0050
Albania	0.0100
Algeria	0.1370
Andorra	0.0080
Angola	0.0100
Antigua and Barbuda	0.0020
Argentina	0.4320
Armenia	0.0070
Australia	2.0741
Austria	0.7981
Azerbaijan	0.0400

¹ Document EB136/37.

Members and Associate Members	WHO scale for 2016–2017 %
Bahamas	0.0170
Bahrain	0.0390
Bangladesh	0.0100
Barbados	0.0080
Belarus	0.0560
Belgium	0.9981
Belize	0.0010
Benin	0.0030
Bhutan	0.0010
Bolivia (Plurinational State of)	0.0090
Bosnia and Herzegovina	0.0170
Botswana	0.0170
Brazil	2.9342
Brunei Darussalam	0.0260
Bulgaria	0.0470
Burkina Faso	0.0030
Burundi	0.0010
Cabo Verde	0.0010
Cambodia	0.0040
Cameroon	0.0120
Canada	2.9842
Central African Republic	0.0010
Chad	0.0020
Chile	0.3340
China	5.1484
Colombia	0.2590
Comoros	0.0010
Congo	0.0050
Cook Islands	0.0010
Costa Rica	0.0380
Côte d'Ivoire	0.0110
Croatia	0.1260
Cuba	0.0690
Cyprus	0.0470
Czech Republic	0.3860
Democratic People's Republic of Korea	0.0060
Democratic Republic of the Congo	0.0030
Denmark	0.6750
Djibouti	0.0010
Dominica	0.0010
Dominican Republic	0.0450
Ecuador	0.0440
Egypt	0.1340

Members and Associate Members	WHO scale for 2016–2017
	%
El Salvador	0.0160
Equatorial Guinea	0.0100
Eritrea	0.0010
Estonia	0.0400
Ethiopia	0.0100
Fiji	0.0030
Finland	0.5190
France	5.5935
Gabon	0.0200
Gambia	0.0010
Georgia	0.0070
Germany	7.1416
Ghana	0.0140
Greece	0.6380
Grenada	0.0010
Guatemala	0.0270
Guinea	0.0010
Guinea-Bissau	0.0010
Guyana	0.0010
Haiti	0.0030
Honduras	0.0080
Hungary	0.2660
Iceland	0.0270
India	0.6660
Indonesia	0.3460
Iran (Islamic Republic of)	0.3560
Iraq	0.0680
Ireland	0.4180
Israel	0.3960
Italy	4.4483
Jamaica	0.0110
Japan	10.8338
Jordan	0.0220
Kazakhstan	0.1210
Kenya	0.0130
Kiribati	0.0010
Kuwait	0.2730
Kyrgyzstan	0.0020
Lao People's Democratic Republic	0.0020
Latvia	0.0470
Lebanon	0.0420
Lesotho	0.0010
Liberia	0.0010

Members and Associate Members	WHO scale for 2016–2017 %
Libya	0.1420
Lithuania	0.0730
Luxembourg	0.0810
Madagascar	0.0030
Malawi	0.0020
Malaysia	0.2810
Maldives	0.0010
Mali	0.0040
Malta	0.0160
Marshall Islands	0.0010
Mauritania	0.0020
Mauritius	0.0130
Mexico	1.8421
Micronesia (Federated States of)	0.0010
Monaco	0.0120
Mongolia	0.0030
Montenegro	0.0050
Morocco	0.0620
Mozambique	0.0030
Myanmar	0.0100
Namibia	0.0100
Nauru	0.0010
Nepal	0.0060
Netherlands	1.6541
New Zealand	0.2530
Nicaragua	0.0030
Niger	0.0020
Nigeria	0.0900
Niue	0.0010
Norway	0.8511
Oman	0.1020
Pakistan	0.0850
Palau	0.0010
Panama	0.0260
Papua New Guinea	0.0040
Paraguay	0.0100
Peru	0.1170
Philippines	0.1540
Poland	0.9211
Portugal	0.4740
Puerto Rico	0.0010

Members and Associate Members	WHO scale for 2016–2017
	%
Qatar	0.2090
Republic of Korea	1.9941
Republic of Moldova	0.0030
Romania	0.2260
Russian Federation	2.4382
Rwanda	0.0020
Saint Kitts and Nevis	0.0010
Saint Lucia	0.0010
Saint Vincent and the Grenadines	0.0010
Samoa	0.0010
San Marino	0.0030
Sao Tome and Principe	0.0010
Saudi Arabia	0.8641
Senegal	0.0060
Serbia	0.0400
Seychelles	0.0010
Sierra Leone	0.0010
Singapore	0.3840
Slovakia	0.1710
Slovenia	0.1000
Solomon Islands	0.0010
Somalia	0.0010
South Africa	0.3720
South Sudan	0.0040
Spain	2.9732
Sri Lanka	0.0250
Sudan	0.0100
Suriname	0.0040
Swaziland	0.0030
Sweden	0.9601
Switzerland	1.0471
Syrian Arab Republic	0.0360
Tajikistan	0.0030
Thailand	0.2390
The former Yugoslav Republic of Macedonia	0.0080
Timor-Leste	0.0020
Togo	0.0010
Tokelau	0.0010
Tonga	0.0010
Trinidad and Tobago	0.0440

Members and Associate Members	WHO scale for 2016–2017 %
Tunisia	0.0360
Turkey	1.3281
Turkmenistan	0.0190
Tuvalu	0.0010
Uganda	0.0060
Ukraine	0.0990
United Arab Emirates	0.5950
United Kingdom of Great Britain and Northern Ireland	5.1794
United Republic of Tanzania	0.0090
United States of America	22.0000
Uruguay	0.0520
Uzbekistan	0.0150
Vanuatu	0.0010
Venezuela (Bolivarian Republic of)	0.6270
Viet Nam	0.0420
Yemen	0.0100
Zambia	0.0060
Zimbabwe	0.0020
Total	100.0000

(Fourteenth meeting, 2 February 2015)

EB136.R10 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: Alliance for Health Promotion; Foundation for Innovative New Diagnostics; Global Diagnostic Imaging, Healthcare IT and Radiation Therapy Trade Association; Global Medical Technology Alliance; Health Technology Assessment international; Humatem; International Epidemiological Association; International Organization for Medical Physics; International Society of Audiology; Medicines for Malaria Venture; RAD-AID International; Tropical Health and Education Trust; and World Federation of Chinese Medicine Societies;

2. FURTHER DECIDES to discontinue official relations with the International Life Sciences Institute.

(Fourteenth meeting, 2 February 2015)

¹ See Annex 2 and decision EB136(6).

² Document EB136/40.

EB136.R11 Confirmation of amendments to the Staff Rules: remuneration of staff in the professional and higher categories¹

The Executive Board,

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

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 2015 concerning the remuneration of staff in the professional and higher categories.

(Fourteenth meeting, 2 February 2015)

EB136.R12 Salaries of staff in ungraded posts and of the Director-General

The Executive Board,

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

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

The Sixty-eighth World Health Assembly,

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

1. ESTABLISHES the salaries of assistant directors-general and regional directors at US\$ 174 371 gross per annum with a corresponding net salary of US\$ 135 560 (dependency rate) or US\$ 122 754 (single rate);
2. ESTABLISHES the salary of the Deputy Director-General at US\$ 191 856 gross per annum with a corresponding net salary of US\$ 147 799 (dependency rate) or US\$ 133 012 (single rate);
3. ESTABLISHES the salary of the Director-General at US\$ 235 889 gross per annum with a corresponding net salary of US\$ 178 622 (dependency rate) or US\$ 158 850 (single rate);
4. DECIDES that those adjustments in remuneration shall take effect on 1 January 2015.

(Fourteenth meeting, 2 February 2015)

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

² Document EB136/47.

EB136.R13 Confirmation of amendments to the Staff Rules¹

The Executive Board,

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

CONFIRMS, in accordance with Staff Regulation 12.2, the amendments to the Staff Rules that have been made by the Director-General with effect from 1 February 2015 concerning the purpose of the Staff Rules; relationship between Staff Regulations and Staff Rules; amendments to the Staff Rules; application of the Staff Rules; effective date of the Staff Rules; exceptions to the Staff Rules; delegation of authority; post classification; payments and deductions; recruitment policies (Staff Rules 410.1, 410.3.2 and 410.3.3); appointment policies; medical certification and inoculations; appointment procedure; effective date of appointment; reinstatement upon re-employment; interorganization transfers; obligation of staff members to provide information about themselves; staff member's beneficiaries; assignment to duty; training; performance management and development; within-grade increase; meritorious within-grade increase; reassignment; reduction in grade; notification and effective date of change in status; official holidays; overtime and compensatory leave; annual leave; home leave; leave for military training or service; approval, reporting and recording of leave; other forms of leave; United Nations Joint Staff Pension Fund; staff health insurance and accident and illness insurance; travel of staff members; right of association; staff member representatives; financing of staff association activities; resignation; termination of temporary appointments; abolition of post; unsatisfactory performance or unsuitability for international service; misconduct; disciplinary measures; misconduct resulting in financial loss; non-disciplinary reprimand; administrative leave pending determination of misconduct; and notification of charges and reply.

(Fourteenth meeting, 2 February 2015)

EB136.R14 Confirmation of amendments to the Staff Rules¹

The Executive Board,

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

CONFIRMS, in accordance with Staff Regulation 12.2, the amendments to the Staff Rules that have been made by the Director-General concerning salary determination; recruitment policies (Staff Rule 410.4); mobility; and refusal of reassignment, with effect from the entry into force of the Organization's mobility policy.

(Fourteenth meeting, 2 February 2015)

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

² Document EB136/47.

EB136.R15 Amendments to the Staff Regulations¹

The Executive Board,

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

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

The Sixty-eighth World Health Assembly,

Noting the recommendations of the Executive Board with regard to the appointment, transfer, reassignment and promotion of staff members; and separation from service:

ADOPTS the proposed amendment to Staff Regulation 4.1;

ADOPTS the proposed amendment to Staff Regulation 4.2;

ADOPTS the proposed amendment to Staff Regulation 4.3;

ADOPTS the proposed amendment to Staff Regulation 4.4;

ADOPTS the proposed amendment to Staff Regulation 9.2;

DECIDES that these amendments shall take effect upon the entry into force of the Organization's mobility policy.

(Fourteenth meeting, 2 February 2015)

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

² Document EB136/47.

DECISIONS

EB136(1) Substandard/spurious/falsely-labelled/falsified/counterfeit medical products

The Executive Board, having considered the report of the third meeting of the Member State Mechanism on substandard/spurious/falsely-labelled/falsified/counterfeit medical products,¹ decided to request that the World Health Assembly postpone the review of the Member State mechanism by one year, to 2017, as proposed by the mechanism in its report.

(Ninth meeting, 30 January 2015)

EB136(2) Principles for global consensus on the donation and management of blood, blood components and medical products of human origin²

The Executive Board, having considered the report by the Secretariat on blood and other medical products of human origin,³

- (1) recalled the guiding principles of the safety, quality and availability of blood and blood products supported by the Health Assembly, through resolutions WHA28.72, WHA58.13 and WHA63.12, as well as the WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation endorsed in resolution WHA63.22;
- (2) noted that several medical products of human origin, which are intended for human clinical application, have significant commonalities in terms of sharing some characteristics inherent in their human origin;
- (3) recognized that protection of the donor is a prerequisite in order to meet the needs of patients for access to safe medical products of human origin, which is of high importance in the context of access to health and universal health coverage;
- (4) acknowledged that medical products of human origin may raise safety issues for donors and recipients;
- (5) recognized that global consensus on the donation and management of medical products of human origin intended for human clinical application, based on good governance mechanisms, is needed in order to protect the fundamental human rights of donors;
- (6) further recognized that appropriate standards to guarantee quality and safety of medical products of human origin and to ensure traceability, vigilance, surveillance and equitable access to these products are essential for the well-being of recipients;

¹ Document EB136/29, Annex.

² See Annex 7 for the financial and administrative implications for the Secretariat of the adoption of the decision.

³ Document EB136/32.

(7) requested that the Director-General convene consultations with Member States and international partners, to support the development of global consensus on guiding ethical principles for the donation and management of the mentioned medical products of human origin; good governance mechanisms; and common tools to ensure quality, safety and traceability, as well as equitable access and availability, as applicable, to result in a document to be submitted to the Seventieth World Health Assembly for its consideration.

(Tenth meeting, 30 January 2015)

EB136(3) Framework of engagement with non-State actors¹

The Executive Board, having considered the report by the Secretariat on the framework of engagement with non-State actors,² and having taken note of the Programme, Budget and Administration Committee report to the Executive Board³ and the report entitled “Framework of engagement with non-State actors: information on regional committee debates”,⁴

(1) noted that important progress has been made in the elaboration of the framework of engagement with non-State actors, but that further improvements are needed especially but not limited to the issues listed in the annex to this decision, with a view to its adoption by consensus at the Sixty-eighth World Health Assembly;

(2) decided to invite Member States⁵ to submit to the Director-General specific proposals for amendments of, additions to or deletions from the text of the draft framework of engagement with non-State actors and the four specific policies as contained in the Annex to document EB136/5 by 16 February 2015;

(3) requested the Director-General to:

(a) compile these proposals and to make them available to Member States⁵ by 9 March 2015;

(b) convene an open-ended intergovernmental meeting from 30 March to 1 April 2015 with a view to discussing the textual proposals submitted by Member States;⁵

(c) submit, based on the outcome of the above intergovernmental meeting, a revised version of the Framework of Engagement with non-State actors to the Sixty-eighth World Health Assembly through the Programme, Budget and Administration Committee.

¹ See Annex 7 for the financial and administrative implications for the Secretariat of the adoption of the decision.

² Document EB136/5.

³ Document EB136/3.

⁴ Document EB136/INF./2.

⁵ And, where applicable, regional economic integration organizations.

ANNEX

**NON-EXHAUSTIVE LIST OF ISSUES WHICH SEEM TO NEED
MORE WORK AMONGST MEMBER STATES**

Conflict of interest (including individual conflict of interest)

Criteria of due diligence and process of risk management

Transparency

Secondments and provision of personnel

Role of private sector (acceptance of funds, pooling mechanism, evidence generation and advocacy)

Engagement with particular industries

Criteria for attribution to type of non-State actors, including criteria applied to classify some nongovernmental organizations as international business associations

In which kind of meetings can non-State actors participate

Use of funds provided by non-State actors to support the salary of WHO staff

Official relations (some aspects)

Policy, norms and standard setting

Applicability of the Framework to all levels of the Organization and all 6 regions

General principles that guide collaboration

Definitions of terms (“arm’s length”, “resources”, etc.)

Support to policy making at national level.

(Eleventh meeting, 30 January 2015)

EB136(4) Outcome of the Second International Conference on Nutrition¹

The Executive Board, recalling relevant WHO international targets and action plans, including the WHO 2025 Global Nutrition Targets² and the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020,³ and having considered the report by the Director-General on the outcome of the Second International Conference on Nutrition,⁴ decided the following:

- (1) to note the commitments of the Rome Declaration on Nutrition and the recommendations of the Framework for Action;
- (2) to request the Director-General:
 - (a) to provide technical support to Member States⁵ to implement the commitments of the Rome Declaration on Nutrition across multiple sectors, by expanding WHO's evidence-informed guidance to cover the policy areas identified in the Framework for Action in the fields covered by WHO's mandate; by developing, as needed, policy papers informed by the best available, robust quality scientific evidence providing the rationale, operational details and necessary elements for the calculation of costs and benefits of the recommended policies, with active involvement of all relevant stakeholders;⁶ by strengthening multilateral initiatives at global and regional levels aimed at sharing experience on implementing different policy approaches or legislative tools; and by creating, together with the Director-General of FAO and in cooperation with other United Nations agencies, a repository of examples of country nutrition plans, including on increased investments to improve people's diet and nutrition, as well as plans that are relevant to nutrition in health, agriculture and trade, social protection, education, water, sanitation, hygiene and the environment;
 - (b) to contribute, together with the Director-General of FAO, to joint United Nations mechanisms on nutrition, such as the United Nations System Standing Committee on Nutrition, the Renewed Efforts Against Child Hunger and Undernutrition (REACH) initiative, the High Level Task Force on the Global Food Security Crisis and the United Nations Interagency Task Force on the Prevention and Control of Non-communicable Diseases, by improving the existing multiagency coordination mechanisms and by developing a United Nations global nutrition agenda, taking account of organizations' respective mandates;
 - (c) to facilitate and enhance the coordination of activities and actions across sectors, based on existing experiences and good practice by preparing policy briefs, as needed, and collaborating, as appropriate, with the Committee on World Food Security and the Global Coordination Mechanism on the prevention and control of noncommunicable diseases; and by maintaining engagement, including with different multistakeholder

¹ See Annex 7 for the financial and administrative implications for the Secretariat of the adoption of the decision.

² See document WHA65/2012/REC/1, Annex 2 for the six global nutrition targets for 2025 adopted by the World Health Assembly in 2012; also see: http://www.who.int/nutrition/topics/nutrition_globaltargets2025/en/ (accessed 5 February 2015).

³ See resolution WHA66.10; see also document WHA66/2013/REC/1, Annex, 4, Appendix 2.

⁴ Document EB136/8.

⁵ And where applicable, regional economic integration organizations.

⁶ In line with the guidance to be provided by the World Health Assembly on engagement with non-State actors.

platforms such as the Scaling Up Nutrition movement, in line with the guidance to be provided by the Health Assembly on engagement with non-State actors;

(d) to contribute, together with the Director-General of FAO, and in close collaboration with other United Nations partners, to accountability, including by inviting Member States to register their commitments in each of the areas indicated by the Framework for Action, as appropriate;

(e) to facilitate consideration of a Decade of Action on Nutrition from 2016 to 2025, within existing structures and available resources, by the United Nations General Assembly in 2015 by preparing a road map jointly with the Director-General of FAO and in cooperation with other United Nations agencies, including proposed milestones, and priority action for governments, international organizations and other actors, and by contributing to informal discussions among Member States;¹

(f) to facilitate informal discussions among Member States with a view to enabling national parliaments to address the follow-up to the Second International Conference on Nutrition at the 132nd Inter-Parliamentary Union Assembly in 2015;

(3) to recommend to the Sixty-eighth World Health Assembly that it:

(a) endorse the Rome Declaration on Nutrition, as well as the Framework for Action, which provides a set of voluntary policy options and strategies for use by governments;

(b) call on Member States¹ to implement commitments of the Rome Declaration through a set of voluntary policy options within the Framework for Action;

(c) request the Director-General, in collaboration with the Director-General of FAO and other United Nations agencies, funds and programmes and other relevant regional and international organizations, to prepare a biennial report to the World Health Assembly on the status of implementation of commitments of the Rome Declaration on Nutrition.

(Twelfth meeting, 31 January 2015)

EB136(5) Strategic budget space allocation²

The Executive Board, having considered the report on strategic budget space allocation³ and the report by the Working Group on Strategic Budget Space Allocation,⁴

(1) welcomed the report of the Working Group on the Strategic Budget Space Allocation and expressed its appreciation to the members of the Working Group for their diligence in developing a methodology in an objective and timely manner;

¹ And, where applicable, regional economic integration organizations.

² See Annex 4, and Annex 7 for the financial and administrative implications for the Secretariat of the adoption of the decision.

³ Document EB136/35.

⁴ Document EB136/35, Annex.

- (2) endorsed the guiding principles recommended by the Working Group;
- (3) requested the Director-General, with respect to the Proposed programme budget 2016–2017:
 - (a) to apply the recommendations of the Working Group with regards to operational segments 2 (provision of global and regional goods), 3 (management and administration) and 4 (response to emergency events, such as outbreak and crisis response);
 - (b) to propose, in consultation with the Global Policy Group (GPG), an allocation of budget space for operational segment 1 (technical cooperation at country level), by applying the guiding principles of the new methodology, the three pillars for the preparation of the 2016–2017 Programme budget (bottom-up approach, realistic costing of outputs and clear roles and responsibilities across the three levels of the Organization) as requested in decision WHA66(9), and taking into account the needs of various regions and comments made by the 136th session of the Executive Board;
- (4) requested the Working Group on Strategic Budget Space Allocation to further develop operational segment 1 (technical cooperation at country level) taking into consideration the issues raised during the 136th session of the Executive Board with regards to the proposed methodology, the choice of appropriate indicators and availability of data, and written comments submitted by Member States to the Secretariat by 28 February 2015, and report to the Executive Board at its 137th session in May 2015;
- (5) decided to expand the membership of the Working Group on Strategic Budget Space Allocation to two Member States per region.

(Fourteenth meeting, 2 February 2015)

EB136(6) Review of nongovernmental organizations in official relations with WHO¹

The Executive Board, having considered and noted the report of its Standing Committee on Nongovernmental Organizations concerning the review of one third of the nongovernmental organizations in official relations with WHO,² and follow-up to decision EB134(7), reached the decisions set out below,

- (1) noting with appreciation their collaboration with WHO and commending their continuing dedication to the work of the Organization, the Board decided to maintain in official relations with WHO the 56 nongovernmental organizations whose names are listed in the Annex to document EB136/40;
- (2) noting also that plans for collaboration had been agreed, the Board decided to maintain in official relations with WHO the International Union for Health Promotion and Education, the Inter-African Committee on Traditional Practices affecting the Health of Women and Children, and the World Psychiatric Association;

¹ See Annex 2.

² Document EB136/40.

(3) noting also that the CMC – Churches’ Action for Health had been incorporated into the World Council of Churches and that it now operates as World Council of Churches, and further noting that a plan for collaboration had been agreed, the Board decided to maintain CMC – Churches’ Action for Health in official relations with WHO under the name World Council of Churches.

(Fourteenth meeting, 2 February 2015)

EB136(7) 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 2015 to Dr Yagoub Yousef Al Mazrou from Saudi Arabia for his significant contribution to public health in Saudi Arabia. The laureate will receive the equivalent of 2500 Swiss francs in United States dollars.

(Fourteenth meeting, 2 February 2015)

EB136(8) 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 2015 to the Childbirth with Dignity Foundation of Poland. The Childbirth with Dignity Foundation is being honoured for its significant and innovative contribution to public health in Poland. The laureate, as an organization, will receive US\$ 40 000.

(Fourteenth meeting, 2 February 2015)

EB136(9) 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 2015 to the “Akogo?” Foundation of Poland, which is being honoured for its innovative contribution to primary health coverage in Poland. The laureate will receive US\$ 20 000.

(Fourteenth meeting, 2 February 2015)

EB136(10) 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 2015 to Dr Alaa Eldien Mohamed El Ghamrawy of Egypt, who is being honoured for his personal contribution to the creation of the National Programme for Rheumatic Heart Disease (RHD) in Egypt. The laureate will receive US\$ 20 000.

(Fourteenth meeting, 2 February 2015)

EB136(11) Amendments to the Statutes of the State of Kuwait Health Promotion Foundation¹

The Executive Board, in accordance with the provisions of Article 11 of the Statutes of the State of Kuwait Health Promotion Foundation, approved the revision of its present Statutes, namely, that Articles 6.3 be deleted and Articles 4, 8 and 11 of the Statutes of the State of Kuwait Health Promotion Foundation be revised in order to: (i) streamline use of funds; (ii) take into account a change in the name of the Prize; (iii) broaden the scope of the purpose of the Prize by providing that it will reward an outstanding contribution to research in the areas of health care for the elderly and in health promotion; (iv) allow for a supplemental funding mechanism; and (v) streamline processes.

(Fourteenth meeting, 2 February 2015)

EB136(12) 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 2015 to the Thalassemia International Federation of Cyprus for their outstanding contribution to public health. The laureate will receive US\$ 100 000.

(Fourteenth meeting, 2 February 2015)

EB136(13) Follow-up to the 2014 high-level meeting of the United Nations General Assembly to undertake a comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases²

The Executive Board decided to request the Director-General to publish a technical note in the coming months on how the Director-General will report in 2017 to the United Nations General Assembly on the national commitments included in the 2014 outcome document³ and 2011 Political Declaration,⁴ using existing survey tools and taking into account existing indicators at the global and regional levels.

(Fourteenth meeting, 2 February 2015)

¹ See Annex 5.

² See Annex 6.

³ See document EB136/11, Annex 1.

⁴ Adopted by the United Nations General Assembly in resolution 66/2 (2011).

EB136(14) Addressing the health impact of air pollution

The Executive Board, having considered the report on addressing the health impact of air pollution,¹ noted the ongoing discussions on the draft resolution under agenda item 7.2, contained in document EB136/CONF./9 Rev.1,² and encouraged Member States to finalize this work, in order for the draft resolution to be duly considered by the Sixty-eighth World Health Assembly.

(Fifteenth meeting, 3 February 2015)

EB136(15) Climate and health: outcome of the WHO Conference on Health and Climate

The Executive Board noted the report by the Secretariat on climate and health: outcome of the WHO Conference on Health and Climate,³ and approved the revised work plan, requesting that the Secretariat take into account the comments made on the work plan during the discussion.

(Fifteenth meeting, 3 February 2015)

EB136(16) Overview of reform implementation⁴

The Executive Board, recalling relevant WHO documents and agreements on WHO reform, and having considered the report by the Secretariat on WHO reform: overview of reform implementation;⁵ recognizing that the pillar of WHO governance reform is essential to bringing the transformational reform process to the desired outcome – which the governing bodies have been working on for more than four years, and further recognizing that the governance pillar can benefit from relevant outcomes from other aspects of WHO reform; and underlining that the process outlined below has a separate mandate and that it should not in any way impede ongoing reform initiatives, emphasizing in particular the outcomes from the Special Session of the Executive Board on Ebola;⁶ and having also considered the recent report of the Independent Expert Oversight Advisory Committee to the twenty-first meeting of the Programme, Budget and Administration Committee,⁷ which states that slow progress on the governance reform pillar could impede the overall WHO reform agenda, and which expresses concern at the lack of alignment in priorities at the three levels of the Organization,

(1) decided:

(a) to establish an inclusive Member States⁸ consultative process on governance reform, to complete its work by the Sixty-ninth World Health Assembly, providing recommendations through the Executive Board on how to improve WHO governance efficiency, with the mandate to address:

¹ Document EB136/15.

² See the summary record of the Executive Board at its 136th session, fifteenth meeting, section 1.

³ Document EB136/16.

⁴ See Annex 7 for the financial and administrative implications for the Secretariat of the adoption of the decision.

⁵ Document EB136/7.

⁶ EBSS/3.

⁷ Document EBPBAC21/2, Annex, in particular, paragraphs 28, 29 and 30.

⁸ And, where applicable, regional economic integration organizations.

- (i) working methods of the governing bodies, including relevant proposals by the Secretariat and the WHO Reform stage 2 evaluation, as well as agenda-setting, including the significant growth in the number of agenda items, resolutions and decisions and its impact on governance, and the functioning of the bureau of the Executive Board and the bureau of the World Health Assembly;
 - (ii) concrete ways to improve the alignment of the governance of all three levels of the Organization, so as to improve accountability and effectiveness;
- (b) that the Member States consultative process should include two meetings open to all Member States¹ with equal participation, as well as the creation of a working group, which will further develop detailed recommendations on both the sub-elements above concerning the mandate of this consultative process. The working group will be made up of two members with relevant experience from each region whose selection and work will be facilitated by the Geneva-based regional coordinators so as to ensure inclusiveness;
- (2) urged Member States¹ to provide their inputs and proposals relevant to the sub-elements in paragraph 1 through the online platform as outlined below, by 2 March, 2015;
- (3) further decided:
 - (a) that the first Member States meeting would take place at a one-day session back to back with the 22nd meeting of the Programme, Budget and Administration Committee in May 2015, which will be reduced to two days, and provide concrete inputs to the working group for its work;
 - (b) that the second Member States meeting will take place by November 2015, and will provide recommendations to the 138th session of the Executive Board;
 - (c) that the working group will meet at least once prior to the first Member States meeting and will provide a preliminary report to it, based on inputs from Member States and the Secretariat as outlined below, and have at least one other meeting before the second Member States meeting, for which it will produce a final report including recommendations;
- (4) requested the Director-General:
 - (a) to establish an online platform to facilitate sharing of the input and proposals of Member States,¹ prior to the first Member States meeting and to maintain the platform throughout this inclusive Member States consultative process;
 - (b) to provide the following on the online platform established according to subparagraph (4)(a):
 - (i) a compendium of existing relevant background documents related to governance reform for the first meeting of the working group and the first Member States meeting, including reports, evaluations, resolutions and decisions;

¹ And, where applicable, regional economic integration organizations.

(ii) an overview of the last ten years of the number of agenda items, number of documents, decisions and resolutions for the Executive Board and World Health Assembly, as well as the number of formal and informal meetings during and between sessions of the governing bodies, and the associated costs;

(iii) a current costing of formal and informal meetings during and between sessions of the governing bodies, including price differences relating to location in Geneva;

(5) requested the Member States consultative process to report to the 138th session of the Executive Board on governance reform, under a separate agenda item, with a view to considering final recommendations from this process, preparatory to consideration by the Sixty-ninth World Health Assembly.

(Fifteenth meeting, 3 February 2015)

EB136(17) Global strategy and plan of action on public health, innovation and intellectual property¹

The Executive Board, having considered the report by the Secretariat on evaluation of the global strategy and plan of action on public health, innovation and intellectual property,²

(1) decided to recommend to the Sixty-eighth World Health Assembly to extend the deadline of the overall programme review of the global strategy and plan of action on public health, innovation and intellectual property on its achievements, remaining challenges and recommendations on the way forward to 2018, recognizing it was not presented in 2015, as requested by resolution WHA62.16;

(2) decided also to recommend to the Sixty-eighth World Health Assembly to extend the time frame of the plan of action on public health, innovation and intellectual property until 2022;

(3) requested the Director-General to provide a report for the Sixty-eighth World Health Assembly on options, in consultation with Member States, for the conduct of the comprehensive evaluation and the overall programme review of the global strategy and plan of action on public health, innovation and intellectual property, on its achievements, remaining challenges and recommendations on the way forward, including whether to combine the two instruments, sequencing, terms of reference, timing and options for establishing an evaluation management group with the goal of completing this exercise by 2018.

(Fifteenth meeting, 3 February 2015)

¹ See Annex 7 for the financial and administrative implications for the Secretariat of the adoption of the decision.

² Document EB136/31.

EB136(18) Provisional agenda for the Sixty-eighth World Health Assembly

The Executive Board, having considered the report of the Director-General on the provisional agenda of the Sixty-eighth World Health Assembly,¹ and recalling its earlier decision that the Sixty-eighth World Health Assembly should be held at the Palais des Nations in Geneva, opening on Monday, 18 May 2015, and closing no later than Tuesday, 26 May 2015,² approved the provisional agenda of the Sixty-eighth World Health Assembly, as amended.³

(Fifteenth meeting, 3 February 2015)

EB136(19) Date and place of the 137th session of the Executive Board

The Executive Board, having considered the proposal in paragraph 5 of document EB136/42, decided that its 137th session should be convened on 27 May and 28 May 2015, at WHO headquarters, in Geneva.

(Fifteenth meeting, 3 February 2015)

EB136(20) Date and place of the 22nd meeting of the Programme, Budget and Administration Committee

Further to decision EB135(8), and taking into account decision EB136(16), the Executive Board decided that the 22nd meeting of the Programme, Budget and Administration Committee shall be held on 14 and 15 May 2015, at WHO headquarters, Geneva. This decision supersedes decision EB135(8).

(Fifteenth meeting, 3 February 2015)

¹ Document EB136/42.

² See decision EB135(8).

³ See the summary record of the Executive Board at its 136th session, fifteenth meeting, section 4.

ANNEXES

ANNEX 1

The recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation¹

[EB136/22 Add.1, Annex 1 – 16 January 2015]

REPORT TO THE DIRECTOR-GENERAL OF THE REVIEW COMMITTEE ON SECOND EXTENSIONS FOR ESTABLISHING NATIONAL PUBLIC HEALTH CAPACITIES AND ON IHR IMPLEMENTATION

13–14 November 2014, Geneva, Switzerland

[Paragraphs 1–15 described the background, appointment of the Review Committee, and organization and process of the meeting.]

IHR IMPLEMENTATION

Progress and challenges

16. The Review Committee noted that considerable progress has been made in implementation of the IHR and reflected on the conclusions and recommendations of the report from the Review Committee on the functioning of the IHR and on pandemic influenza A (H1N1) 2009. The Committee noted that key achievements include: establishment and functionality of National IHR Focal Point entities (NFPs); increased transparency in reporting events, using early warning systems more systematically; better communication and collaboration between animal and human health sectors; coordinated collective efforts of countries and partners to build capacities (e.g. the Asia Pacific Strategy for Emerging Diseases (2010), Integrated Disease Surveillance and Response); establishment of emergency response coordination structures; and better international mechanisms to share information for rapid response. These achievements are the result of significant efforts made by States Parties, WHO, and donor programmes. Core capacities at central, intermediate and local levels are essential public health functions that are beneficial not only to the individual country, but to the global community.

17. Though progress had been made in many areas, the Review Committee emphasized that countries in every Region still face significant challenges to fully implement the IHR. Key impediments to IHR implementation include: insufficient authority/capacity of NFPs; the misconception that implementation of the IHR is the sole responsibility of ministries of health; limited involvement/awareness of sectors other than human health; limited investment of national financial and human resources; high staff turnover; ongoing complex emergencies/conflict; the specific needs of small island states and States Parties with overseas territories; the focus on IHR extensions of the deadlines rather than on an expansion of capacities; a perception that implementation is a rigid, legal

¹ See resolution EB136.R6 and document EB136/2015/REC/2, summary record of the eighth meeting, section 1.

process with less emphasis on operational implications and learning from experience; and limited international solidarity to support the weakest countries in building capacities. States Parties' self-assessment of their implementation of the IHR is limited by the variable quality and reliability of information that is provided.

Requests for second extensions

18. The Review Committee was provided detailed country-level requests and implementation plans in advance of the meeting for their review. The Secretariat also provided aggregated analyses of the requests for second extensions; States Parties were grouped based on the completeness of the implementation plan which accompanied their second extension request and on their monitoring framework scores. The Review Committee heard the analysis and thoughts expressed by WHO regional offices representatives.

19. The Review Committee considered the variability between the different extension requests; e.g. the number of core capacities requested for extension, the reasons for doing so, and the completeness of proposed implementation plans. Some of the exceptional circumstances and obstacles to full implementation of the IHR cited by States Parties in their requests, included: the need for more time; financial, economic or public health issues (e.g., *“mass vaccination campaigns competing for resources, and various ongoing outbreaks”*); the lack of human resources; long-running emergencies (e.g., *“due to protracted emergencies caused by conflicts over three decades”*, *“significant gaps in infrastructure, human resources, human development, education and health continue to exist”*); internal or external political issues (e.g., *“unprecedented military and political crisis that has disrupted the socio-economic plan, the operation of the administration, and disorganized the healthcare system at all levels for the implementation of activities”*); and natural disasters.

Conclusion 1

20. The work to develop, strengthen and maintain the core capacities under the IHR should be viewed as a continuing process for all countries.

21. The current Ebola virus disease (EVD) outbreak has underscored the importance of having strong national and local capacities in place to rapidly detect, respond and take preventative measures to contain a serious public health threat. At the same time, it has highlighted the fragile nature of health systems in some countries, as well as the importance of a multi-sectoral approach. It is therefore of concern that only approximately one-third of States Parties have indicated that they have met the minimum core capacity requirements.

22. In formulating its advice to the Director-General, the Review Committee felt it was essential to consider the implementation status of all States Parties and not just those Parties that have requested a second extension. The Review Committee recommends the following for the Director-General's consideration:

Recommendation 1

23. States Parties that have indicated they have met the minimum core capacity requirements should be commended for their considerable efforts. At the same time, they should be reminded that implementation of the IHR is a dynamic, ongoing process that must be continually assessed, maintained and strengthened as needed. These countries should be urged to continue their efforts to maintain and strengthen their core capacities, and to consider providing support to other States Parties that face technical, financial, political or other obstacles in establishing core capacities.

Recommendation 2

24. *All States Parties that have requested a second extension (or do so at a future date) should be granted the extension for 2014–2016. In granting this extension, the Director-General should note if the request was accompanied by an implementation plan and if so, whether or not the plan adequately addressed the criteria for the extensions noted by the Sixty-sixth World Health Assembly. In communicating with the State Party, the Director-General may also take into account other relevant information that relates to the core capacities for that country. The Director-General's communication with the State Party could also be used by WHO regional and country offices to engage with the State Party and where appropriate, serve as a basis for priority setting, establishing next steps, and resource mobilization. WHO (at headquarters, regional and country levels) should continue to support these countries, as needed, in their efforts to implement core capacities.*

Recommendation 3

25. *States Parties that have not communicated their intentions to WHO should be reminded of the importance of transparency in relation to both the letter and the spirit of the IHR. These States Parties likely represent a diverse group ranging from those that may have met the requirements for core capacities but not reported to that effect, to those that have made limited progress. WHO should make further attempts to contact these States Parties, offer assistance, and provide them with the opportunity to: request an extension if it is needed; or indicate that they have met the minimum requirements under IHR Annex 1 and that, therefore, no extension is necessary.*

Recommendation 4

26. *States Parties, stakeholders, and donor programmes should be encouraged to provide technical and financial assistance as needed. States Parties should be encouraged to use guidelines and tools that WHO has developed, or may in the future develop, to support implementation of the IHR.*

Short-term action to accelerate IHR implementation

27. The Committee discussed ways in which additional improvements could be made during the extension period. It was felt that not all NFPs are sufficiently empowered; they needed to be well positioned within the public health system with appropriate seniority and close to where decisions are taken, particularly during emergencies.
28. Laboratory services and surveillance systems should be better linked to improve integrated surveillance. A lesson learnt from EVD and other events is the value of having and using existing public health capacities and networks during emergencies. The diagnostic capacity of national and intermediate level laboratories should be enhanced by connecting them to surveillance networks including those connected to health centres and clinics, and through quality assurance, quality control programmes, and biological risk management.
29. There is a need to strengthen and build multisectoral surveillance capabilities at local and community levels, with trained staff working with clinicians, and to promote integration of surveillance systems for both communicable diseases and other hazards and to establish early warning alert and response systems where needed.

30. More can be done to strengthen data management as applied to both laboratories and epidemiological surveillance. The challenges in data management include: difficulties handling multiple inputs from different sources; lack of reporting from some areas; lack of data management standards; and lack of linkages between data sets. Data collection at community level is weak in many outbreaks. Outbreak reviews at the local and national level should be encouraged and WHO should facilitate meta-evaluations of the last 20 major outbreaks to help provide evidence-based guidance.

31. One of the major challenges to IHR implementation is building up core capacities at points of entry, particularly in terms of surveillance, preparedness and response capacities. EVD has demonstrated the importance of adequate core capacity implementation at designated airports, ports and ground-crossings. Approaches or tools which integrate demography, migration, health burden, animal-human interface, transport hubs, volume of air traffic and the like into web-based applications, could assist risk assessment. Identification of high-risk international points of entry for the spread of diseases could facilitate prioritized capacity implementation at points of entry on a more scientific basis. In the context of EVD, exit screening can be used for security, and entry screening can be used as an opportunity for education, awareness raising and monitoring. It was emphasized that cross-border cooperation for the development of risk mapping, surveillance and coordinated responses to diseases and events is critical.

32. In the context of the current EVD epidemic, public health measures that have consequential implications for travel and trade raise complex and difficult issues that require very careful consideration; a review, possibly by an ad hoc technical group and/or formal evaluative analysis, is needed to identify lessons from recent experience, and assess from a public health perspective, and the wider social and economic effects, what works, what does not and why. At the technical and political level, additional measures taken by countries that vary from Temporary Recommendations made by the WHO Director-General in public health emergencies of international concern pose special challenges (e.g. in the context of EVD, blanket travel bans are measures which exceed the Temporary Recommendations). States Parties can apply such additional measures, but only under the conditions laid out in Article 43 of the Regulations. A State Party affected by an additional measure may request consultations with the implementing State Party in order to find a mutually acceptable solution (Article 43 paragraph 7 of the Regulations). WHO also can, and should, seek to obtain the public health rationale for additional measures, and share this with other countries. Where no rationale is forthcoming, this too may be disclosed for example, via the event information site.

33. The health and safety of frontline health care workers in outbreak situations or other public health events was considered to be critical. One key approach to their protection is training; recent outbreaks have shown that, where healthcare workers were well trained, fewer became infected. It is also important to build health workers' confidence and to ensure adequate numbers by providing appropriate support; e.g., through health insurance and regular salary payments. In the current Ebola epidemic, the Review Committee acknowledged the heroism shown by many frontline health care workers, often under the most difficult of circumstances, and in many cases, at the cost of their own lives.

Recommendation 5

34. ***The Committee recommends States Parties to:***

- (a) *Review, and where appropriate, strengthen and empower NFPs to enable effective performance of key IHR functions, facilitate decision making and ensure high level support for multi-sectoral communication and cooperation*
- (b) *Support the formation of multidisciplinary outbreak investigation and response teams, including animal health expertise where appropriate*

- (c) *Foster an operational approach in which cooperation between countries, results in practical and sustainable solutions to surveillance, laboratory, and other capacities in small islands and other small States*
- (d) *Use a risk assessment approach to prioritise public health threats, capacity gaps and to identify priority points of entry for designation and capacity building*
- (e) *Build the confidence of health care workers through policy measures that promote protection of and respect for health care workers' rights.*

Recommendation 6

35. ***The Committee also recommends to the Director-General to consider establishing technical working groups to:***

- (a) *Strengthen data management capacities and practices; and*
- (b) *Review the lessons learned from current and past experience with public health measures that have had negative implications for travel, transport and trade.*

Longer-term commitment to the IHR to prevent the international spread of public health threats

36. The IHR (2005) have been tested repeatedly in recent years by the continued emergence and re-emergence of infectious disease, such as influenza, polio, MERS-CoV, and EVD, the majority of them zoonotic (i.e. infecting both humans and animals), underscoring the usefulness of a “One Health” approach. The possibility of harm from radiological and chemical hazards is also of concern, contributing to an increasingly complex world in which the global community will continue to face an array of diverse threats to its health and well-being. It is critical, therefore, that the IHR are seen, and used, as an essential tool in contributing to global health security.

37. States Parties envisioned a long life for the IHR (2005): “By not limiting the application of the IHR (2005) to specific diseases, it is intended that the Regulations will maintain their relevance and applicability for many years to come even in the face of the continued evolution of diseases and the factors determining their emergence and transmission.”¹

38. Against this backdrop, the Review Committee considered the longer-term development of and commitment to the IHR core capacities. The Review Committee noted that the principles and key themes of the IHR provide an important foundation upon which to construct a long-term approach:

- The IHR recognize the interdependence between countries with respect to both threats to public health and the respective capacities of countries to manage those threats.
- The IHR provide a risk-based framework that recognizes the different nature of various threats and of the measures needed to address them.
- Proportionality is an important consideration that can be applied to capacity building (e.g. capacities of small developing island States will never match those of large countries) as well as to response measures, which should be commensurate with and restricted to public health risks.

¹ See Foreword to the International Health Regulations (2005), Second Edition.

- Implementation of the Regulations should be “... guided by the goal of their universal application for the protection of all people of the world from the international spread of disease ...”.¹

Methodologies for the shorter- and longer-term development of IHR capacities

39. To move countries towards greater IHR functionality, it is essential to have better information on the robustness of States Parties’ core capacities. States Parties currently report on their progress in implementing the Regulations through a self-assessment approach that is facilitated by WHO data collection instruments and supporting tools. The Review Committee discussed the advantages and challenges to approaches that would build upon a basic “checklist” approach to methodologies that can better assess quality and functional performance. Options discussed included assisted self-assessments, voluntary independent evaluations, peer reviews and certifications.

40. Systematic reviews of States Parties’ or regions’ responses to disease outbreaks and other public health events is another way of assessing capacities in a more integrated and arguably useful fashion. It was noted that there are no processes or systems currently in place to institutionalize collection and dissemination of observations and “lessons learned”.

Conclusion 2

41. Implementation of the IHR should now advance beyond simple “implementation checklists” to a more action-oriented approach to periodic evaluation of functional capacities.

42. The Review Committee noted that implementation of the “theoretical construct” of the IHR has now been tested against the realities of public health threats and the varying capacities and resources of States Parties to address them. In light of this experience, implementation of the IHR should now advance beyond simple “implementation checklists” so there is a more action-oriented approach to periodic evaluation of functional capacities. This will require a carefully prepared “roadmap” including regional engagement with States Parties for improvement.

Recommendation 7

43. *The Review Committee recommends that the Director-General consider a variety of approaches for the shorter- and longer-term assessment and development of IHR core capacities as follows:*

States Parties should urgently: (i) strengthen the current self-assessment system (e.g., if not already done, the annual self-assessment reports and planning processes should be enhanced through multi-sectoral and multi-stakeholder discussions); and (ii) implement in-depth reviews of significant disease outbreaks and public health events. This should promote a more science or evidence-based approach to assessing effective core capacities under “real-life” situations. Simultaneously, the Secretariat should promote a series of regional formal evaluations or meta-evaluations of the outbreak reviews, managed by the regional offices, to facilitate cross-region learning and to distil lessons learnt for future IHR programming.

¹ See Article 3, paragraph 3, of the IHR.

In parallel, and with a longer term vision, the Secretariat should develop through regional consultative mechanisms options to move from exclusive self-evaluation to approaches that combine self-evaluation, peer review and voluntary external evaluations involving a combination of domestic and independent experts. These additional approaches should consider, amongst other things, strategic and operational aspects of the IHR, such as the need for high level political commitment, and whole of government / multi-sectoral engagement. Any new monitoring and evaluation scheme should be developed with the active involvement of WHO regional offices and subsequently proposed to all States Parties through the WHO governing bodies' process.

44. This performance oriented information needs to be supplemented by information of an advocacy nature that demonstrates to States Parties, especially potential donors, the value of providing additional support to IHR post 2016. One example of this potential advocacy material would be economic analysis of the costs of international public health events, such as, SARS, Avian Influenza, MERS CoV, Ebola Viral Disease etc. and the benefits of maintaining and enhancing core IHR capacities.

Recommendation 8

45. ***A comprehensive, time-phased, prioritized plan for continued implementation and maintenance of the IHR to guide longer-term capacity development for the IHR should be developed based on the outcomes of the consultative process, analytic reviews and analyses mentioned above. Such a plan should be both realistic and with aspirational components, taking into account the wide disparities in States Parties' capacities and resources. Consideration should be given to delineating the basic core capacities that should be in place for all countries.***

Resource requirements

46. The development and maintenance of core capacities require extensive and sustained financial and personnel resources for States Parties. Of particular concern, as noted by the IHR Emergency Committee for EVD, is the fragile nature of health systems and other relevant sectors needed for a multisectoral response in some countries "with significant deficits in human, financial and material resources, resulting in a compromised ability to mount an adequate ... outbreak control response."¹

47. In some cases, States Parties alone cannot supply the resources to develop and maintain core capacities, as well as mount a surge response for potential public health emergencies of international concern. The private sector has an important supporting role. The Review Committee emphasized that it is in the interest of the private sector to contribute resources for public health preparedness and response. Infectious and other public health events can have considerable direct and indirect economic ramifications for the private sector (e.g. commerce, travel, tourism, entertainment, sports), as well as the directly affected countries.

48. Well-resourced countries and intergovernmental and non-governmental entities have made significant contributions (e.g. financial, technical, supplies/materials, and personnel) in response to the EVD outbreak. Mobilization of these resources, however, has taken considerable time and effort. In this connection, it was noted that the Review Committee on the Functioning of the IHR (2005) in relation to Pandemic (H1N1) 2009 made two relevant recommendations: (1) the establishment of a

¹ Statement on the 1st meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa, available at <http://www.who.int/mediacentre/news/statements/2014/ebola-20140808/en/>.

more extensive global, public health reserve work force; and (2) the creation of a contingency fund for public health emergencies.¹ Progress in implementing these recommendations has been limited to the creation of the African Public Health Emergency Fund. Urgent support by States Parties, including through WHO governing bodies, is required.

49. The Committee re-emphasized the findings of the Review Committee on the Functioning of the IHR and on Pandemic Influenza A (H1N1) in May 2011, namely that “WHO’s capacity to prepare and respond in a sustained way to any public health emergency is severely limited by chronic funding shortfalls, compounded by restrictions on the use of funds from Member States, partners and donors.”²

Recommendation 9

50. ***The Review Committee recommends that the Director-General encourage dialogue among States Parties and public and private partners, including large NGOs, to improve cooperation and assistance:***

- (a) *Obtain support for the sustained development and maintenance of national capacities over the long-term, with particular attention to countries requesting extensions/countries with significant capacity gaps;*
- (b) *Create a response fund, as recommended by the first Review Committee, for use in public health emergencies of international concern that can be readily available for future events; and*
- (c) *Create a more extensive global, public-health reserve work force that can be mobilized as part of a sustained response to a public health emergency of international concern.*

Recommendation 10

51. ***The Review Committee encourages the States Parties to support WHO through financial and staffing resources in preparation for, and during, public health emergencies of international concern.***

[The Annex concludes with four appendices.]

¹ See http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_10-en.pdf?ua=1.

² Ibid.

ANNEX 2

Nongovernmental organizations admitted into, or maintained in, official relations with WHO by virtue of resolution EB136.R10 and decision EB136(6)

[EB136/40, Annex – 31 January 2015]

Alliance for Health Promotion
Caritas Internationalis*
CBM*
CMC – Churches' Action for Health under the name World Council of Churches
CropLife International*
European Centre for Ecotoxicology and Toxicology of Chemicals*
European Society for Medical Oncology*
FDI World Dental Federation*
Foundation for Innovative New Diagnostics
Global Diagnostic Imaging, Healthcare IT and Radiation Therapy Trade Association
Global Medical Technology Alliance
Health Technology Assessment international
Helen Keller International*
Humatem
Inter-African Committee on Traditional Practices affecting the Health of Women and Children
International Agency for the Prevention of Blindness*
International AIDS Society*
International Air Transport Association*
International Association for Dental Research*
International Association for Hospice and Palliative Care Inc.*
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 Epidemiological Association
International Eye Foundation*
International Federation of Oto-Rhino-Laryngological Societies*
International Leprosy Association*
International Medical Corps*
International Network for Cancer Treatment and Research*
International Network on Children's Health, Environment and Safety*
International Organization for Medical Physics
International Society of Audiology
International Society for Environmental Epidemiology*

International Society of Doctors for the Environment*
International Society of Nephrology*
International Solid Waste Association*
International Union against Sexually Transmitted Infections*
International Union Against Tuberculosis and Lung Disease*
International Union for Health Promotion and Education
International Union of Immunological Societies*
International Union of Toxicology*
March of Dimes Foundation*
Medicines for Malaria Venture
Organisation pour la Prévention de la Cécité*
Project ORBIS International, Inc.*
RAD-AID International
Rotary International*
Stichting Global Network of People Living with HIV/AIDS (GNP+)*
Thalassaemia International Federation*
The Global Alliance for Rabies Control, Inc.*
The International Association of Lions Clubs*
The International Federation of Anti-Leprosy Associations*
The Royal Commonwealth Society for Blind (Sightsavers)*
The Worldwide Hospice Palliative Care Alliance*
Tropical Health and Education Trust
Union for International Cancer Control*
WaterAid*
World Blind Union*
World Council of Optometry*
World Federation of Chinese Medicine Societies
World Federation of Hemophilia*
World Federation of Hydrotherapy and Climatotherapy*
World Heart Federation*
World Hepatitis Alliance*
World Hypertension League*
World Plumbing Council*
World Psychiatric Association
World Stroke Organization*
World Veterinary Association*

* Based on reports of collaboration for the period under review 2012–2014, the Standing Committee on Nongovernmental Organizations recommended the maintenance in 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.

ANNEX 3

Amendments to the Staff Regulations and confirmation of amendments to the Staff Rules¹

[EB136/47 – 16 January 2015]

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. In accordance with Staff Regulation 12.1,¹ proposed amendments to the Staff Regulations are submitted to the Executive Board, which is requested to recommend their adoption by the Sixty-eighth World Health Assembly.
3. 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-ninth session, on the basis of recommendations made by the International Civil Service Commission in its annual report for 2014.³ Should the United Nations General Assembly not approve the Commission's recommendations, an addendum to the present report will be issued.
4. The amendments described in section II of this document are made in the light of experience and in the interest of good human resources management.
5. The amendments described in section III of this document also are made and proposed in the light of experience and in the interest of good human resources management. They would take effect from the entry into force of the Organization's mobility policy.
6. The financial implications of the amendments for the biennium 2014–2015 involve negligible additional costs under the Programme budget 2014–2015, which will be met from the appropriate allocations established for each region and for global and interregional activities. They are set out in the report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly, along with the financial implications beyond the biennium 2014–2015.⁴
7. The proposed amendments to the Staff Regulations and the amended Staff Rules are set out in the Annexes.

¹ See resolutions EB136.R11, EB136.R13, EB136.R14 and EB136.R15.

² Basic documents, available at <http://apps.who.int/gb/bd/>.

³ Official record of the General Assembly, Sixty-ninth session, Supplement No. 30 (document A/69/30).

⁴ Document EB136/47 Add.1.

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

Remuneration of staff in the professional and higher categories

8. The Commission recommended to the United Nations General Assembly that the current base/floor salary scale for the professional and higher categories should be increased by 1.01% through the standard consolidation method of increasing base salary and commensurately reducing post adjustment multiplier points (that is, on a “no loss, no gain” basis) with effect from 1 January 2015.

9. Amendments to Appendix 1 of the Staff Rules have been prepared accordingly and are set out in [Attachment 1 to this text].

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

10. Subject to the decision of the United Nations General Assembly in respect of the recommendation in paragraph 8 above, the Director-General proposes, in accordance with Staff Regulation 3.1, that the Executive Board recommend to the Sixty-eighth World Health Assembly modifications in the salaries of assistant directors-general and regional directors. Thus, as from 1 January 2015, the gross salary for assistant directors-general and regional directors would be US\$ 174 371 per annum, and the net salary US\$ 135 560 (dependency rate) or US\$ 122 754 (single rate).

11. 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 2015, a gross salary of US\$ 191 856 per annum with a corresponding net salary of US\$ 147 799 (dependency rate) or US\$ 133 012 (single rate).

12. 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 2015, would therefore be US\$ 235 889 per annum gross, US\$ 178 622 net (dependency rate) or US\$ 158 850 net (single rate).

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

General changes throughout the Staff Rules

13. In order to ensure consistency, the language throughout the Staff Rules has been standardized where possible. The phrases “the Rules” and “these Rules” have been replaced with “the Staff Rules”. The word “staff” has been replaced with “staff member” or “staff members” as appropriate. The phrases “official station” and “official duty station” have been replaced with “duty station”.

Purpose

14. Staff Rule 010 has been amended for editorial reasons and is now Staff Rule 010.1. Former Staff Rule 015.2 is now Staff Rule 010.2.

Relationship between Staff Regulations and Staff Rules

15. Some editorial amendments have been made and Staff Rule 015.2 has been merged into Staff Rule 010.

Amendments

16. Staff Rule 020 has been amended for editorial reasons.

Application

17. Staff Rule 030 has been amended for editorial reasons.

Effective date

18. Staff Rule 040 has been amended to indicate that, subject to Staff Rule 040.2, the effective date of these Staff Rules, with the exception of Appendix 1, is 1 February 2015. The effective date of Appendix 1 (salary scale) is 1 January 2015.

19. Staff Rule 040.2 has been introduced to indicate that the effective date of the listed Staff Rules is the date of entry into force of the Organization's mobility policy.

Exceptions to the Staff Rules

20. Staff Rule 050 has been amended for editorial reasons.

Delegation of authority

21. Staff Rule 060 has been amended for editorial reasons.

Post classification

22. In Staff Rule 210, the phrase "in the Global Management System" has been deleted as it is not necessary to mention where the human resources plans are established and approved. The location of human resources plans can change over time, and staff members can be informed of such changes in information notes.

Payments and deductions

23. It has been decided that when a staff member has, in good faith, received an overpayment of an allowance or entitlement of any kind, the Organization will, in the case of a recurring payment, recover the amount overpaid during the two years prior to the date on which the Organization discovered the overpayment. In the case of a lump sum payment, the Organization will recover the amount overpaid provided that the recovery action is initiated within two years following the date of overpayment. Staff Rule 380.8 has been introduced accordingly. Staff Rule 380.7 has been amended for editorial reasons.

Recruitment policies

24. In Staff Rule 410.1, the word "efficiency" has been added so that the wording corresponds with that in Staff Regulation 4.2.

25. Staff Rules 410.3.2.1 and 410.3.2.2 have been amended for editorial reasons.

26. In Staff Rule 410.3.3, reference to the WHO eManual has been deleted. Most of the Staff Rules have corresponding provisions in the eManual. It is not necessary to reference the eManual in the Staff Rules.

Appointment policies

27. Staff Rules 420.4, 420.6 and 420.7 have been amended for editorial reasons.

Medical certification and inoculations

28. Staff Rule 430.1 has been amended to clarify that before accepting an offer of appointment, a person is a “candidate”, not an “appointee”. Furthermore, it is not necessary for the Organization to designate the physician carrying out the prescribed medical examination, only that the physician is qualified.

29. Staff Rule 430.2 has been amended to clarify that candidates must be medically fit before they can be appointed to a post.

30. Staff Rule 430.3 has been amended for editorial reasons.

31. Staff Rule 430.5 has been amended to remove the mandatory nature of the medical examination for staff members who go on leave without pay, as many do not require such an examination. The Staff Physician, or a physician designated by the Organization, will decide whether a medical examination is required.

Appointment procedure

32. Staff Rule 440.1 has been amended for editorial reasons. Rather than specifying some of the conditions that must be met before an offer of appointment is made, Staff Rule 440.1 should refer to the conditions generally.

33. In Staff Rule 440.1.1, the word “duties” has been changed to “grade”. An offer of appointment sets out the grade of the post, and not its duties, which are contained in the post description.

34. Staff Rule 440.2 has been amended for editorial reasons. For clarity, the words “Staff Regulation 1.10” have been added to avoid any misunderstanding concerning the oath or declaration to which reference is made.

35. Staff Rule 440.3 has been amended to indicate that the terms of appointment must not only be confirmed, they must be recorded. Some editorial amendments also have been made.

Effective date of appointment

36. Staff Rule 450.1 has been amended to indicate that the effective date of appointment is not based on whether the staff member is locally recruited, but whether the Organization authorized travel for the staff member to take up his appointment.

37. Staff Rule 450.2 has been amended as it is sufficient to state that a person cannot travel or report for duty until the appointment procedure has been completed, because completion of medical requirements is part of the appointment procedure.

Reinstatement upon re-employment

38. Staff Rules 470.1 and 470.2 have been amended for editorial reasons.

Interorganization transfers

39. In Staff Rule 480.1.1, the words “net base” have been added to provide more accuracy.

40. Staff Rule 480.2 has been amended for editorial reasons.

Obligation of staff members to provide information about themselves

41. Staff Rule 490.1 has been amended to conform to the language of the similar provision in the Staff Rules and Staff Regulations of the United Nations and to stress that staff members shall be held accountable for the accuracy and completeness of the information that they provide.

42. Staff Rule 490.2 has been amended for editorial reasons.

Staff member’s beneficiaries

43. Staff Rule 495.2 has been amended for editorial reasons.

Assignment to duty

44. Staff Rule 510.1 has been amended for editorial reasons.

Training

45. Staff Rule 520 has been amended to stress that training can be helpful to staff members both in their current and future positions in the Organization.

Performance management and development

46. Staff Rule 530 has mainly been amended for editorial reasons.

47. Staff Rule 530.2 has been added to emphasize that staff members and their supervisors share responsibility for the success of the performance management process. Staff Rules 530.1, 530.3, 530.4 and 530.5 have been renumbered accordingly.

48. Staff Rule 530.4 has been amended to note the importance of supervisors recognizing good performance in addition to suggesting ways to improve performance.

49. Staff Rule 530.5 has been amended to account for the fact that forms are frequently certified electronically as opposed to physically signed.

Within-grade increase

50. The amendments to Staff Rule 550 are mainly editorial.
51. In Staff Rule 550.1, reference to Staff Rule 555.2 has been deleted because Staff Rule 555 has been deleted. Some editorial amendments also have been made.
52. Staff Rule 550.6 has been amended to clarify that it relates to the accrual of service time for a within-grade increase. Some editorial amendments also have been made.

Meritorious within-grade increase

53. Staff Rule 555.1 is not mandatory and has not been applied by the Organization for many years. It has been deleted.
54. Staff Rule 555.2 has been deleted because there are no longer any staff members who would qualify for this mandatory within-grade increase.

Reassignment

55. Staff Rule 565.4 has been amended for editorial reasons.

Reduction in grade

56. Staff Rule 570.1 has been amended for editorial reasons.

Notification and effective date of change in status

57. Staff Rule 580 has been amended mainly for editorial reasons.
58. Staff Rule 580.2 has been amended to allow for notification to be given in any form of writing, not necessarily a letter.

Official holidays

59. Staff Rule 620 has been amended for editorial reasons.

Overtime and compensatory leave

60. Staff Rule 625 has been amended for editorial reasons.

Annual leave

61. Staff Rule 630 has been amended mainly for editorial reasons.
62. In Staff Rule 630.3.3, the phrase “special leave under insurance cover” has been replaced by “sick leave under insurance cover” to provide more accuracy.
63. Staff Rule 630.7 has been amended to clarify that it is the Staff Physician who approves medical reports.

Home leave

64. Staff Rule 640 has been amended mainly for editorial reasons.
65. In Staff Rule 640.6.4, the word “eligible” has been inserted before “children” because not all children of a staff member are eligible for home leave.

Leave for military training or service

66. Staff Rules 660.1 and 660.3 have been amended for editorial reasons.

Approval, reporting and recording of leave

67. Staff Rule 670 has been amended to reflect the fact that the staff member is responsible for ensuring that all leave taken is promptly reported and recorded. Some editorial amendments also have been made.

Other forms of leave

68. Staff Rule 680 has been deleted because it is not necessary.

United Nations Joint Staff Pension Fund

69. Staff Rule 710 has been amended for editorial reasons.

Staff health insurance and accident and illness insurance

70. Staff Rule 720 has been amended for editorial reasons.

Travel of staff members

71. Staff Rule 810 has been amended mainly for editorial reasons.
72. Staff Rule 810.5 has been amended to clarify the circumstances under which the Organization will pay for the travel of a staff member on a family visit.
73. Staff Rule 810.7 has been added in order to emphasize that the cost of travel covered by Staff Rule 810 shall not exceed that of travel from the duty station to the staff member’s recognized place of residence. Staff Rules 810.8 and 810.9 have been renumbered accordingly.

Right of association

74. Staff Rule 910 has been amended for editorial reasons.

Staff member representatives

75. Staff Rule 920 has been amended for editorial reasons.

Financing of staff association activities

76. Staff Rule 930 has been amended for editorial reasons.

Resignation

77. Staff Rule 1010.1, 1010.2, 1010.3 and 1010.4 have been amended for editorial reasons.

Termination of temporary appointments

78. The amendments to Staff Rule 1045 are mainly editorial.

79. Staff Rule 1045.1.2 has been amended to broaden the description of what constitutes unsatisfactory performance in performance management policies, as the description in Staff Rule 1045.1.2 is no longer sufficient.

Abolition of post

80. Staff Rule 1050.1 has been amended to clarify that both fixed-term and continuing appointments may be terminated if the occupied post is abolished. Some editorial amendments also have been made.

Unsatisfactory performance or unsuitability for international service

81. The amendments to Staff Rule 1070 are mainly editorial.

82. Staff Rule 1070.1 has been amended to broaden the description of what constitutes unsatisfactory performance in performance management policies, as the description in Staff Rule 1070.1 is no longer sufficient.

Misconduct

83. Staff Rules 1075.1 and 1075.2 have been amended for editorial reasons.

Disciplinary measures

84. Staff Rule 1110.1 has been amended to expand the range of disciplinary measures. It will give the Organization more flexibility when disciplining staff members who have been found guilty of misconduct, as the current options are too limited. This expanded range of disciplinary measures conforms to the range of disciplinary measures in other organizations in the United Nations system.

Misconduct resulting in financial loss

85. Staff Rule 1112 has been introduced to clarify that staff members may be required to compensate the Organization for any financial loss suffered as a result of their misconduct.

Non-disciplinary reprimand

86. Staff Rule 1115 has been introduced to allow a written reprimand in cases where a staff member's conduct, although not appropriate, may not warrant a disciplinary measure.

Administrative leave pending determination of misconduct

87. Staff Rule 1120 has been amended to clarify the conditions of administrative leave pending determination of misconduct.

88. Staff Rule 1120.1 has been amended to emphasize that administrative leave without pay is an exceptional measure.

89. Staff Rule 1120.2 has been amended to indicate that administrative leave can involve more than just prohibiting the staff member's presence in the office, but that it can also involve prohibiting his access to equipment and documents.

90. Staff Rule 1120.3 has been amended to emphasize that administrative leave under Staff Rule 1120 is not a disciplinary measure. If a charge of misconduct is not sustained, the administrative leave shall end immediately. Any pay that has been withheld shall be promptly paid if misconduct is not established.

Notification of charges and reply

91. Staff Rule 1130 has been amended for editorial reasons.

III. AMENDMENTS CONSIDERED NECESSARY IN THE LIGHT OF EXPERIENCE AND IN THE INTEREST OF GOOD HUMAN RESOURCES MANAGEMENT WHICH, IF CONFIRMED¹ AND ADOPTED², WOULD TAKE EFFECT FROM THE ENTRY INTO FORCE OF THE ORGANIZATION'S MOBILITY POLICY³

Proposed amendments to the Staff Regulations

Appointment, transfer, reassignment and promotion

92. The proposed amendments to the title of Article IV of the Staff Regulations and Staff Regulations 4.2 and 4.3 are editorial.

93. Amendments are proposed to Staff Regulation 4.1 to emphasize that all appointments, transfers, reassignments and promotions shall be made as required and without regard to race, sex or religion.

94. When the Organization's mobility policy enters into force, many posts will be filled by the reassignment of staff members instead of through an unrestricted competition. Amendments are proposed to Staff Regulation 4.4 to make this point clear.

Separation from service

95. A staff member's refusal or failure to take up a reassignment, including under the Organization's mobility policy, will be grounds for terminating the staff member's appointment. It is proposed to amend Staff Regulation 9.2 accordingly.

¹ In the case of amendments to the Staff Rules.

² In the case of proposed amendments to the Staff Regulations.

³ [The existing and proposed revised texts are set out in Attachment 3.]

Amendments to the Staff Rules**Salary determination**

96. Staff Rule 320.3.1 has been introduced in order to provide a basis for calculating the salary of a staff member who is reassigned to a lower graded post as part of the mobility process. Staff Rule 320.3.3 has been renumbered accordingly and has been amended for editorial reasons.

Recruitment policies

97. Staff Rule 410.4 has been amended to clarify that most rotational posts held by staff members on continuing or fixed-term appointments will be filled by reassignment pursuant to the Organization's mobility policy.

Mobility

98. Staff Rule 515 has been introduced. It gives preference under the mobility exercise to certain staff members whose posts have been abolished.

Refusal of reassignment

99. Staff Rule 1072 has been introduced. It sets out the consequences of a staff member refusing, or failing to take up, a reassignment.

ACTION BY THE EXECUTIVE BOARD

100. [This paragraph contained five draft resolutions, which were adopted at the fourteenth meeting as resolutions EB136.R11, EB136.R12, EB136.R13, EB136.R14 and EB136.R15, respectively.]

ATTACHMENT 1
(Appendix 1 to the Staff Rules)
SALARY SCALE FOR THE PROFESSIONAL AND HIGHER CATEGORIES: ANNUAL GROSS SALARIES
AND NET EQUIVALENTS AFTER APPLICATION OF STAFF ASSESSMENT (IN US DOLLARS)
(effective 1 January 2015)

Step

Level	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	XIII	XIV	XV
		*			*	*	*	*							
D.2 Gross	143 073	146 104	149 138	152 264	155 427	158 589									
Net D	113 443	115 656	117 871	120 085	122 299	124 512									
Net S	104 219	106 087	107 948	109 804	111 655	113 495									
D.1 Gross	130 745	133 410	136 066	138 730	141 395	144 053	146 719	149 379	152 129						
Net D	104 444	106 389	108 328	110 273	112 218	114 159	116 105	118 047	119 990						
Net S	96 540	98 228	99 915	101 595	103 274	104 948	106 615	108 282	109 943	*	*	*	*	*	*
P.5 Gross	108 148	110 412	112 678	114 941	117 210	119 471	121 740	124 003	126 268	128 533	130 799	133 062	135 329		
Net D	87 948	89 601	91 255	92 907	94 563	96 214	97 870	99 522	101 176	102 829	104 483	106 135	107 790		
Net S	81 704	83 174	84 638	86 102	87 564	89 020	90 477	91 930	93 381	94 829	96 276	97 716	99 158	*	*
P.4 Gross	89 035	91 056	93 075	95 094	97 115	99 133	101 249	103 434	105 621	107 804	109 993	112 175	114 362	116 549	118 736
Net D	73 338	74 934	76 529	78 124	79 721	81 315	82 912	84 507	86 103	87 697	89 295	90 888	92 484	94 081	95 677
Net S	68 294	69 746	71 200	72 646	74 095	75 542	76 989	78 431	79 873	81 315	82 752	84 191	85 629	87 064	88 498
P.3 Gross	73 181	75 051	76 922	78 787	80 659	82 528	84 396	86 268	88 137	90 006	91 878	93 746	95 616	97 485	99 353
Net D	60 813	62 290	63 768	65 242	66 721	68 197	69 673	71 152	72 628	74 105	75 584	77 059	78 537	80 013	81 489
Net S	56 766	58 123	59 484	60 840	62 201	63 558	64 914	66 275	67 631	68 990	70 343	71 699	73 049	74 405	75 759
P.2 Gross	60 025	61 697	63 370	65 043	66 715	68 385	70 059	71 729	73 401	75 076	76 746	78 419			
Net D	50 420	51 741	53 062	54 384	55 705	57 024	58 347	59 666	60 987	62 310	63 629	64 951			
Net S	47 292	48 491	49 686	50 884	52 080	53 278	54 494	55 708	56 927	58 142	59 354	60 574			
P.1 Gross	46 956	48 453	49 941	51 548	53 152	54 759	56 367	57 977	59 580	61 186					
Net D	39 913	41 185	42 450	43 723	44 990	46 260	47 530	48 802	50 068	51 337					
Net S	37 649	38 820	39 991	41 160	42 329	43 499	44 669	45 824	46 974	48 124					

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

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

ATTACHMENT 2

TEXT OF AMENDED STAFF RULES

010. PURPOSE

010.1 The Staff Rules implement the provisions of the Staff Regulations and govern the conditions of service of the World Health Organization (the “Organization”).

010.2 The Staff Rules are established by the Director-General under the authority of the Staff Regulations and are subject to confirmation by the Executive Board. The Staff Rules shall be consistent with the Staff Regulations.

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015. RELATIONSHIP BETWEEN STAFF REGULATIONS AND STAFF RULES

015.2 [Deleted]

.....

020. AMENDMENTS

Subject to confirmation by the Executive Board, the Staff Rules may be amended by the Director-General in a manner consistent with the Staff Regulations and without prejudice to the acquired rights of staff members under the Staff Regulations.

.....

030. APPLICATION

The Staff Rules apply to all staff members of the Organization, except as provided otherwise in any particular Staff Rule. Nothing in the Staff Rules prevents the Director-General from making temporary appointments of 60 days or less with terms of service different from those provided in the Staff Rules, where the Director-General considers that the interests of the Organization so require.

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040. EFFECTIVE DATE

040.1 Subject to Staff Rule 040.2, and with the exception of Appendix 1, these Staff Rules are effective as from 1 February 2015 and supersede all Staff Rules in force before that date. Appendix 1 is effective as from 1 January 2015.

040.2 The amendments to Staff Rules 320.3, 410.4, 515 and 1072 are effective as from the entry into force of the Organization’s mobility policy.

.....

050. EXCEPTIONS TO THE STAFF RULES

The Director-General may make exceptions to the Staff Rules. Such exceptions shall not be inconsistent with any Staff Regulation or decision of the World Health Assembly. Furthermore, each exception shall be agreed to by the staff member directly affected and, in the opinion of the Director-General, shall not prejudice the interests of any other staff member or group of staff members.

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060. DELEGATION OF AUTHORITY

The Director-General may delegate to other officers of the Organization such of his powers as he considers necessary for the effective implementation of the Staff Rules.

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210. POST CLASSIFICATION

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

.....

380. PAYMENTS AND DEDUCTIONS

...

380.7 The Organization will not accept a claim for an allowance or entitlement of any kind that is submitted more than one year after the date when the initial payment would have been due.

380.8 When a staff member has, in good faith, received an overpayment of an allowance or entitlement of any kind, the Organization will, subject to conditions established by the Director-General:

380.8.1 in the case of a recurring payment, recover the amount overpaid during the two years prior to the date on which the Organization discovered the overpayment; and

380.8.2 in the case of a lump sum payment, recover the amount overpaid provided that the recovery action is initiated within two years following the date of overpayment.

.....

410. RECRUITMENT POLICIES

- 410.1 The paramount considerations in the selection of staff members shall be efficiency, competence and integrity. For posts in the professional category and above, geographical representation shall also be given full consideration. Such representation is not a consideration in appointments to posts subject to local recruitment.

...

- 410.3.2 A staff member who is related to another staff member as specified under Staff Rules 410.3 and 410.3.1:

410.3.2.1 shall not be assigned to a post that is superior or subordinate in the line of authority to the post occupied by the staff member to whom he or she is related.

410.3.2.2 shall not participate in the process of selection, assignment, reassignment or transfer of the related staff member; or in the taking or reviewing of an administrative decision affecting the related staff member.

- 410.3.3 The marriage of one staff member to another shall not affect the contractual status of either spouse, but their entitlements and other benefits shall be modified as provided in the Staff Rules. The same modifications shall apply in the case of a staff member whose spouse is a staff member of another Organization participating in the United Nations common system.

.....

420. APPOINTMENT POLICIES

...

- 420.4 A “temporary appointment” is a time-limited appointment of up to two years. The total duration of uninterrupted service under consecutive temporary appointments shall not exceed two years. A staff member who has completed the maximum period of uninterrupted service on one or more temporary appointments may not be employed by the Organization unless more than 30 calendar days have elapsed since his separation from service. Any future employment is subject to conditions established by the Director-General.

...

- 420.6 All staff members, including those seconded to the Organization, shall be appointed initially on a fixed-term appointment as defined in Staff Rule 420.3, or on a temporary appointment as defined in Staff Rule 420.4.

- 420.7 Any fixed-term appointment of one year or more shall be subject to a period of probation, which shall be at least one year and may be extended up to two years when necessary for adequate evaluation of the staff member's performance, conduct and suitability for international service.

.....

430. MEDICAL CERTIFICATION AND INOCULATIONS

- 430.1 Upon selection, a candidate shall undergo a prescribed medical examination by a qualified physician whose medical report shall be forwarded to the Organization's Staff Physician.
- 430.2 Before an offer of appointment can be made, medical clearance must be issued by the Staff Physician; medical clearance is based on the examination required in Staff Rule 430.1. Should the examination show that the candidate is not medically fit to be appointed to the post, a decision shall be made whether or not to make an offer of appointment and, if an offer is to be made, upon what terms.
- 430.3 Upon appointment and before any subsequent travel for the Organization, a staff member shall have such inoculations and preventive treatment as the Staff Physician requires.
- ...
- 430.5 Prior to going on leave without pay, a staff member may be required to undergo a medical examination by the Staff Physician or by a physician designated by the Organization.

[No further changes]

.....

440. APPOINTMENT PROCEDURE

- 440.1 Upon selection for a post, a candidate shall receive notification of the proposed appointment and the conditions to be met before an offer of appointment can be made. When these conditions have been satisfactorily met, the candidate shall receive an offer of appointment which shall:
- 440.1.1 state the type of appointment, tenure, probation requirement, title and grade of post, salary and allowances;
- 440.1.2 indicate the date and place of reporting for duty and the duty station;
- 440.1.3 include a copy of the Staff Regulations and the Staff Rules and state that the offer is subject to the current provisions of the Staff Regulations and the Staff Rules and any subsequent amendments;
- ...

- 440.2 A candidate shall sign and return to the Organization his acceptance of the conditions contained in the offer, his acceptance of the Staff Regulations and Staff Rules as a part of his contract of employment, and his adherence to the oath or declaration of office in Staff Regulation 1.10.
- 440.3 The offer of appointment, including the Staff Regulations and Staff Rules, and the candidate's acceptance shall constitute the contract of employment. The terms of the appointment shall be confirmed and recorded when the staff member reports for duty and shall be subsequently modified as necessary to reflect any change in status.

[No further changes]

.....

450. EFFECTIVE DATE OF APPOINTMENT

- 450.1 The effective date of appointment shall be the date the staff member reports for duty if travel is not authorized. If travel is authorized it shall be the date he enters travel status, provided that this date is not earlier than that required for travel by the route and type of transport designated by the Organization.
- 450.2 A person shall not report for duty, or commence any travel for the purpose of entering on duty, until the appointment procedure in Staff Rule 440 has been completed.
-

470. REINSTATEMENT UPON RE-EMPLOYMENT

- 470.1 Staff members, except those holding temporary appointments as defined in Staff Rule 420.4, who are re-employed within one year of their separation from service, may, at the option of the Organization, be reinstated. In such cases they shall have restored to them the status which they held upon separation, and the intervening absence shall be charged to annual leave and leave without pay as necessary. They shall refund to the Organization all separation payments made to them.
- 470.2 A former staff member who is re-employed, but not reinstated under the provisions of Staff Rule 470.1, shall have the same status as if he were being employed for the first time.

[No further changes]

.....

480. INTERORGANIZATION TRANSFERS

- 480.1 Subject to the requirements of Staff Rules 430 and 440 ("Medical Certification and Inoculations" and "Appointment Procedure"), appointees accepted for transfer from another United Nations organization:

- 480.1.1 may be appointed at an advanced step in the grade of the post to which they are being assigned if this is necessary to maintain their existing net base salary level;

...

- 480.2 A staff member who is transferred to another United Nations organization shall not be paid a repatriation grant or any other terminal benefit. The transferred staff member's credit for all entitlements shall be passed to the receiving organization. The subsequent entitlements of the staff member shall be governed by the rules of the receiving organization.

490. OBLIGATION OF STAFF MEMBERS TO PROVIDE INFORMATION ABOUT THEMSELVES

- 490.1 Staff members are responsible for providing the Organization with whatever information and documentation may be required, both during the application process and subsequent employment, for the purpose of determining their status under the Staff Rules or of completing administrative arrangements in connection with their appointments. Staff members shall be held accountable for the accuracy and completeness of the information they provide.
- 490.2 Staff members are responsible for promptly notifying the Organization, in writing, of any subsequent changes affecting their status under the Staff Rules, and for providing all relevant information and documentation.

[No further changes]

495. STAFF MEMBER'S BENEFICIARIES

...

- 495.2 In the event of the death of a staff member, all amounts due to that staff member will be paid to his or her nominated beneficiary or beneficiaries, except as otherwise stated in these Staff Rules and the Regulations of the United Nations Joint Staff Pension Fund. Such payment shall release the World Health Organization from any and all liability in respect of any sum so paid.

510. ASSIGNMENT TO DUTY

- 510.1 Staff members in the professional category are subject to assignment by the Director-General to any activity or office of the Organization throughout the world. Those in the general service category are not subject to assignment, except by mutual agreement, to a duty station other than that for which they have been recruited. Initial recruitment for a specific assignment does not, therefore, relieve the staff member of the obligation to serve in any other designated assignment. In determining the initial and any subsequent

assignment, consideration shall be given, to the extent possible, to the staff member's particular abilities and interests.

[No further changes]

.....

520. TRAINING

Staff members may be given suitable training, as determined necessary by the Organization, to improve their effectiveness for current and future assignments in the Organization.

.....

530. PERFORMANCE MANAGEMENT AND DEVELOPMENT

530.1 The performance management and development process shall be the basis for assisting a staff member to make his most effective contribution to the work of the Organization and for decisions concerning the staff member's status and retention in the Organization.

530.2 Performance management and development is a shared responsibility between staff members and their supervisors.

530.3 Supervisors shall be responsible for:

530.3.1 facilitating the adjustment of the staff they supervise to their work;

530.3.2 establishing, in consultation with each staff member, a work plan;

530.3.3 guiding staff under their supervision.

530.4 In addition to normal work review and discussion with a staff member, supervisors shall periodically make a formal evaluation of the performance, conduct and development potential of all staff members under their supervision. This evaluation shall be made at such intervals as the work situation or the individual's performance requires, but in no case less frequently than once a year. Supervisors shall discuss their conclusions with the staff member, recognize good performance and make specific suggestions for improvement in performance as necessary. For staff members with supervisory responsibilities, the evaluation shall include an assessment of their performance as supervisors, including how they fulfil their performance management and development responsibilities.

530.5 The performance of staff members during the preceding year shall be evaluated according to procedures established by the Director-General. The relevant form shall be certified by the supervisors and the staff member concerned. Staff members may attach a statement concerning any part of the performance evaluation report with which they disagree and this statement shall become part of their performance file.

.....

550. WITHIN-GRADE INCREASE

550.1 Staff members whose performance has been certified by their supervisors as satisfactory shall be entitled to a within-grade salary increase of one step upon completion of each unit of service time as defined in Staff Rule 550.2. For staff members holding fixed-term appointments subject to a period of probation, the date of entitlement shall not be earlier than the date of confirmation of the appointment except as provided in Staff Rule 480. The effective date for a within-grade increase shall be the first of the month nearest the date of satisfactory completion of the service requirement. Increases may be granted up to the maximum for the staff member's grade except that, if Staff Rule 1310.9 applies, the normal maximum may be exceeded accordingly.

550.2 The unit of service time is defined as the minimum length of time which must be served at a step in order to achieve a within-grade increase under the terms of Staff Rule 550.1. The unit of service time is as follows:

550.2.1 one year of full-time service at all levels and steps except at those in Staff Rule 550.2.2;

...

550.2.3 such period of full-time service as the Director-General may establish for posts subject to local recruitment in accordance with Staff Rule 1310.

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

...

550.6 Accrual of service time for a within-grade increase shall start from the latest of the following actions:

550.6.1 entry on duty;

550.6.2 the last within-grade increase;

550.6.3 reduction in grade under Staff Rule 570.1.2; or

550.6.4 a promotion to a higher grade.

565. REASSIGNMENT

...

- 565.4 A staff member with a continuing or fixed-term appointment may be required, without formal reassignment and in the interests of the Organization, to perform duties of a post other than his own, due regard being given to the provisions of Staff Rule 320.4. Any such arrangement shall not exceed twelve months, unless otherwise decided by the Director-General.
-

570. REDUCTION IN GRADE

- 570.1 The grade of staff members may be reduced as a consequence of reclassification of the post occupied or reassignment to a different post of lower grade. The latter may result from:

570.1.1 the staff member's own request for personal reasons;

570.1.2 unsatisfactory performance or misconduct; or

570.1.3 as an alternative to termination under Rule 1050.

[No further changes]

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580. NOTIFICATION AND EFFECTIVE DATE OF CHANGE IN STATUS

- 580.1 Staff members shall be notified in writing, either individually or collectively, of any changes in their official status, whether arising from actions taken under the Staff Rules or from any other changes in their personal or employment situation recognized by the Organization. Such notification shall constitute an amendment to the terms of appointment under Staff Rule 440.3.

- 580.2 A staff member shall be notified in writing in advance of any reduction in grade or salary, the notice period being the same as that specified for termination in Staff Rule 1050.9.
-

620. OFFICIAL HOLIDAYS

Ten holidays are observed per year. Except as otherwise decided by the Director-General, eight of the ten days shall be fixed following, as far as practicable, the most commonly observed holidays in the locality, and two days to be taken at the discretion of individual staff members, the timing of which shall be subject to the requirements of service.

.....

625. OVERTIME AND COMPENSATORY LEAVE

- 625.1 When authorized by the appropriate supervisor, a staff member may be required to work overtime and may be compensated as follows, subject to procedures established by the Director-General:

625.1.1 staff in posts in the professional category and above may be given compensatory leave;

625.1.2 staff in posts subject to local recruitment shall be given compensatory leave or monetary compensation.

630. ANNUAL LEAVE

630.1 Annual leave is provided to staff members for the purposes of rest and relaxation from their duties and for attending to personal business. Absences not specifically covered by the Staff Rules shall be chargeable to annual leave to the extent that annual leave has been accrued or advanced.

...

630.3 Annual leave accrues to all staff members except:

630.3.1 conference and other short-term service staff engaged on a daily basis under Staff Rule 1320;

630.3.2 those on leave without pay under Staff Rule 655.1 in excess of 30 days;

630.3.3 those on sick leave under insurance coverage in excess of 30 days.

...

630.5 Not more than 15 days of annual leave accrued in a given year shall normally be carried forward to the next calendar year. Not more than 60 days of accumulated annual leave can be carried forward beyond 31 December of each year.

...

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

630.8 A staff member who, on leaving the service of the Organization, has not exhausted the annual leave to which he is entitled shall be paid in respect of each day of unused annual leave up to a maximum of 30 days (see Staff Rule 380.2.2). A staff member who has taken advanced annual leave beyond that subsequently accrued shall either have the equivalent amount debited to his terminal payments or at the option of the Organization make a cash refund. In case of death of a staff member, payment in lieu of accrued annual leave shall be made to his or her nominated beneficiary or beneficiaries under Staff Rule 495.2 but no deduction shall be made in respect of advanced annual leave.

640. HOME LEAVE

...

640.2 The date of eligibility for home leave shall be the date on which the staff member has completed 24 months of qualifying service, except at those official stations designated by the Director-General as having difficult conditions of life and work. At such designated official stations, the date of eligibility shall be the date on which the staff member has completed 12 months of qualifying service. The date may be determined according to criteria established by the Director-General in cases of reassignment or reclassification of official stations. All official stations are classified for this purpose, according to their home leave cycle, as “24-month stations” or “12-month stations”.

640.3 Staff members are eligible for home leave when:

...

640.3.3 they are not locally recruited under Staff Rules 1310 and 1330; and

640.3.4 they have met the requirements for qualifying service under Staff Rule 640.4.

...

640.5 Home leave consists of travel time not charged to the staff member’s annual leave with return transportation paid by the Organization for the staff member, the spouse and eligible children, up to the cost of travel between the official station and the staff member’s recognized place of residence or the actual destination, whichever is less. Travel shall be authorized as follows:

640.5.1 travel shall be between the official station and the staff member’s recognized place of residence or another place as provided for in Staff Rule 640.1;

640.5.2 as a condition for the payment of travel, the staff member, the spouse and eligible children must spend a reasonable period of time in the country where the leave is exercised.

640.6 Home leave may be granted subject to the following conditions:

...

640.6.3 the spouse and eligible children must remain at the official station for at least six months after return from home leave if the staff member is assigned to a 24-month duty station, or for at least three months if the staff member is assigned to a 12-month duty station;

640.6.4 the timing of the home leave must be reasonable in relation to other authorized travel of the staff member, spouse or eligible children, and in relation to the exigencies of the service.

[No further changes]

.....

660. LEAVE FOR MILITARY TRAINING OR SERVICE

660.1 Upon application, staff members, except those holding temporary appointments as defined in Staff Rule 420.4, may be granted leave of absence for a period of up to the full duration of the military training or service required by their government. At the staff members' option, such absence shall be charged as either leave without pay or as annual leave to the extent accrued and thereafter to leave without pay. During any period of leave without pay for this purpose, Staff Rule 655.2 shall apply.

...

660.3 Upon application, within 90 days after release from military service, the staff member shall return to active duty in service with the Organization in the same status he had at the time he entered military service, provided there is a post available at his level which is not occupied by a person of higher retention status. If no such post is available, the provisions of Staff Rule 1050 shall be applied to determine his status and entitlements.

.....

670. APPROVAL, REPORTING AND RECORDING OF LEAVE

The granting of leave under Staff Rules 625, 630, 640, 650 and 655 is subject to the exigencies of service and must be approved in advance by authorized officials. The personal circumstances of the staff member shall be considered to the extent possible. It is the staff member's responsibility to ensure that all leave taken is promptly reported and recorded.

.....

710. UNITED NATIONS JOINT STAFF PENSION FUND

Staff members shall be participants in the United Nations Joint Staff Pension Fund if the Regulations and Rules of the United Nations Joint Staff Pension Fund so require.

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720. STAFF HEALTH INSURANCE AND ACCIDENT AND ILLNESS INSURANCE

Staff Health Insurance

720.1 Staff members shall participate in the Organization's Staff Health Insurance scheme, and their spouse and eligible dependants shall also be covered in accordance with rules established by the Director-General in consultation with staff representatives. Staff members shall contribute to the cost.

Accident and Illness Insurance

720.2 Staff members shall be insured against the risk of disability or accidental death to the extent provided for in the Organization's accident and illness insurance policy relating to them. Staff members shall contribute to the cost.

.....

810. TRAVEL OF STAFF MEMBERS

The Organization shall pay the travel expenses of staff members as follows:

- 810.1 on appointment, from the recognized place of residence to the duty station, or, at the option of the Organization, from the place of recruitment if different;
- 810.2 on change of duty station;
- ...
- 810.5 on family visit, once between home leave eligibility dates (or once during an appointment of equivalent duration) as set out in Staff Rule 640.2 from the duty station to the place where the staff member's spouse and children, as defined in Staff Rule 820.1, are residing, and return to the duty station, provided that:
 - 810.5.1 the staff member has waived his entitlements to the travel of his spouse and children under Staff Rules 820 and 825, except for education grant travel under Staff Rules 820.2.5.2 and 820.2.5.3;
 - 810.5.2 the staff member's assignment is to continue for at least six months after his return if he is assigned to a 24-month duty station or for at least three months if he is assigned to a 12-month duty station; and
 - 810.5.3 there is a reasonable interval between family visit travel and travel on home leave (see also Staff Rule 640.6.4);
- 810.6 On separation, except as provided in Staff Rule 1010.2, from the duty station to the recognized place of residence, or to any other place.
- 810.7 The cost to the Organization for travel covered by this Staff Rule shall not in any case exceed that of travel from the duty station to the staff member's recognized place of residence.
- 810.8 In the case of illness or injury requiring special facilities for treatment of a staff member whom the Organization has an obligation to repatriate, the Director-General may authorize return travel between the duty station and the nearest place where such facilities exist. The Staff Physician advises on the location of the facilities. To the extent feasible, such travel shall subsequently be charged to entitlements becoming due under Rules 810.4, 810.5, 810.6 and 870.
- 810.9 In exceptional circumstances, and in accordance with conditions established by the Director-General, return travel may be authorized in the case of illness or injury requiring special facilities for the treatment of a staff member whom the Organization does not have an obligation to repatriate.

.....

910. RIGHT OF ASSOCIATION

Staff members, at any duty station or location, shall have the right to associate in a formal organization for the purpose of developing staff activities and making proposals and representations to the

Organization concerning personnel policy and conditions of service. The staff members at different duty stations and locations shall have the right to form an association of all staff members for the same purposes. The staff members of the Organization may associate themselves with the staff members of other United Nations organizations in the development of joint activities and in the expression of views on matters related to international civil service.

.....

920. STAFF MEMBER REPRESENTATIVES

In any consultations concerning personnel policy or conditions of service, the duly elected representatives of the staff members shall be recognized by the Organization as representing the views of that portion of the staff members from which they have been elected. Any proposal to change the Staff Regulations or Staff Rules of the Organization shall be referred to the duly elected representatives of the staff members for comment.

.....

930. FINANCING OF STAFF ASSOCIATION ACTIVITIES

Staff associations shall have the right to ask their membership for voluntary financial contributions. The Organization may give financial assistance to any such association in the furtherance of activities beneficial to staff members, provided that the membership of the association also contributes substantially to such activities. The finances of any staff association receiving assistance from the Organization shall be subject to audit procedures which are acceptable to the Organization.

.....

1010. RESIGNATION

1010.1 Subject to the conditions stated in Staff Rule 1010.2, staff members holding continuing or fixed-term appointments may resign on giving three months' notice. Staff members holding temporary appointments of more than 60 days may resign on giving one month's notice. Temporary staff members appointed for a shorter period shall give the notice specified in their appointment. The Director-General may shorten or waive the required notice period at his discretion.

1010.2 A staff member holding an appointment of one year or more or an appointment of less than one year which is subsequently extended resulting in an uninterrupted period of service of one year or more, who resigns before completing a year of service forfeits all entitlement to repatriation transportation at the Organization's expense for himself, his spouse and dependent children and their possessions.

1010.3 A staff member assigned to a 24-month duty station who resigns within six months from the date of return from travel on home leave or from the date of qualifying for it, whichever is later, or from travel under Rule 810.5, forfeits entitlement to repatriation travel at the Organization's expense for himself and his family members who accompanied him on such travel. If the staff member exercises his entitlement under Staff Rule 820.2.6 and resigns within six months from the starting date of such travel, he forfeits entitlement to his repatriation travel at the Organization's expense. Exceptions may be granted by the Director-General in case of resignation compelled by exceptional circumstances.

- 1010.4 A staff member assigned to a 12-month duty station who resigns within three months from the date of return from travel on home leave or from the date of qualifying for it, whichever is later, or from travel under Staff Rule 810.5, forfeits entitlement to repatriation travel at the Organization's expense for himself and his family members who accompanied him on such travel. If the staff member exercises his entitlement under Staff Rule 820.2.6 and resigns within three months from the starting date of such travel, he forfeits entitlement to his repatriation travel at the Organization's expense. Exceptions may be granted by the Director-General in case of resignation compelled by exceptional circumstances.

1045. TERMINATION OF TEMPORARY APPOINTMENTS

- 1045.1 In addition to the grounds for termination set out in Staff Rules 1030, 1075, and 1080, a temporary appointment may be terminated prior to its expiration date if:
- 1045.1.1 the function the staff member performs is discontinued, or;
- 1045.1.2 the staff member's performance is deemed to be unsatisfactory, or if the staff member proves unsuited to his work or to international service.
- 1045.2 When a temporary appointment is terminated due to discontinuation of the function, the staff member will be given at least one month's notice and will be paid a termination indemnity in accordance with the schedule set out in Staff Rule 1050.10.
- 1045.3 When a temporary appointment is terminated for unsatisfactory performance or because the staff member proves unsuited to his work or to international civil service, the staff member shall normally be given at least one month's notice. In addition, the staff member may, at the discretion of the Director-General, be paid an indemnity not exceeding one-half of the amount to which he would have been entitled if his appointment had been terminated under Staff Rule 1045.2.

1050. ABOLITION OF POST

- 1050.1 Subject to Staff Rules 1050.2 and 1050.3, the fixed-term or continuing appointment of a staff member may be terminated if the post that he occupies is abolished.

[No further changes]

1070. UNSATISFACTORY PERFORMANCE OR UNSUITABILITY FOR INTERNATIONAL SERVICE

- 1070.1 A staff member's continuing or fixed-term appointment may be terminated if his performance is unsatisfactory or if he proves unsuited to his work or to international service.

...

1070.3 A staff member with a continuing or fixed-term appointment whose appointment is terminated under this Rule shall be entitled to a notice period equivalent to that specified in Staff Rule 1050.9.

1070.4 A staff member whose continuing or fixed-term appointment is terminated under this Rule may, at the discretion of the Director-General, be paid an indemnity not exceeding one-half of the amount to which he would have been entitled if terminated under Staff Rule 1050.

1075. MISCONDUCT

1075.1 A staff member may be dismissed for misconduct as defined in Staff Rule 110.8, subject to the notification of charges and reply procedure required by Staff Rule 1130. The staff member shall be given one month's notice. The Director-General may grant such staff member an indemnity not exceeding one-half of that payable under Staff Rule 1050.10. No end-of-service grant is payable.

1075.2 A staff member may be summarily dismissed for serious misconduct, if the seriousness of the misconduct warrants it, subject to the notification of charges and reply procedure required by Staff Rule 1130. Such staff member shall not be entitled to notice of termination, indemnity, repatriation grant or end-of-service grant.

1110. DISCIPLINARY MEASURES

1110.1 A staff member who fails to observe the standards of conduct as defined under Article I of the Staff Regulations and Staff Rule 110 shall be subject to disciplinary measures. According to the gravity of the misconduct, this may take the form of any one or a combination of the following:

1110.1.1 written censure, to be retained in the staff member's personal record for five years, following which it will be removed;

1110.1.2 fine of up to three months' net base salary;

1110.1.3 loss of up to three steps at grade;

1110.1.4 suspension with partial or no pay for up to one month;

1110.1.5 reduction in grade;

1110.1.6 dismissal;

1110.1.7 summary dismissal for serious misconduct.

1112. MISCONDUCT RESULTING IN FINANCIAL LOSS

A staff member whose misconduct results in a financial loss suffered by the Organization may be required to partially or fully compensate the Organization.

.....

1115. NON-DISCIPLINARY REPRIMAND

Should a staff member's conduct not be serious enough to warrant initiating disciplinary action, or imposing a disciplinary measure, a written reprimand may be given. Such a reprimand does not constitute disciplinary measures.

.....

1120. ADMINISTRATIVE LEAVE PENDING DETERMINATION OF MISCONDUCT

1120.1 In a case of alleged misconduct involving a staff member, if it is considered that the staff member's continued performance of functions is likely to prejudice the interests of the Organization, the staff member may be placed on administrative leave pending a conclusion on the allegation of misconduct. Such administrative leave may be with or, exceptionally, without pay.

1120.2 At the time of administrative leave under this Staff Rule, the staff member shall be given a written statement containing the reason for the administrative leave, his status during the administrative leave, and its probable duration. The statement may also specify the conditions under which the staff member may have access to WHO premises, equipment and documents.

1120.3 Administrative leave under this Staff Rule, with or without pay, shall not be considered a disciplinary measure. If misconduct is not established, the administrative leave shall end immediately. If the staff member is placed on administrative leave without pay and misconduct is not established, the amount withheld shall be promptly paid.

.....

1130. NOTIFICATION OF CHARGES AND REPLY

A disciplinary measure listed in Staff Rule 1110.1 may be imposed only after the staff member has been notified of the charges made against him and has been given an opportunity to reply to those charges. The notification and the reply shall be in writing, and the staff member shall be given eight calendar days from receipt of the notification within which to submit his reply. This period may be shortened if the urgency of the situation requires it.

.....

ATTACHMENT 3

TEXT OF PROPOSED AMENDMENTS TO THE STAFF REGULATIONS

Existing text	Proposed text
STAFF REGULATIONS – ARTICLE IV Appointment and Promotion	STAFF REGULATIONS – ARTICLE IV Appointment, Transfer, Reassignment and Promotion
4.1 The Director-General shall appoint staff members as required.	4.1 The Director-General shall appoint, transfer, reassign and promote staff members as required- without regard to race, sex or religion.
4.2 The paramount consideration in the appointment, transfer, reassignment or promotion of the staff shall be the necessity of securing the highest standards of efficiency, competence and integrity. Due regard shall be paid to the importance of recruiting and maintaining the staff on as wide a geographical basis as possible.	4.2 The paramount consideration in the appointment, transfer, reassignment or promotion of the staff members shall be the necessity of securing the highest standards of efficiency, competence and integrity. Due regard shall be paid to the importance of recruiting and maintaining the staff members on as wide a geographical basis as possible.
4.3 Selection of staff members shall be without regard to race, creed or sex. So far as is practicable, selection shall be made on a competitive basis; however, the foregoing shall not apply to the filling of a position by transfer or reassignment of a staff member without promotion in the interest of the Organization.	4.3 Selection of staff members shall be without regard to race, creed or sex. So far as is practicable, selection shall be made on a competitive basis; however, the foregoing shall not apply to the filling of a positions by transfer or reassignment of a staff member without promotion in the interest of the Organization.
4.4 Without prejudice to the inflow of fresh talent at the various levels, vacancies shall be filled by promotion of persons already in the service of the Organization in preference to persons from outside. This preference shall also be applied, on a reciprocal basis, to the United Nations and specialized agencies brought into relationship with the United Nations.	4.4 Without prejudice to the inflow of fresh talent at the various levels, vacancies posts shall be filled by promotion reassignment of staff members, as defined by, and under conditions established by, the Director-General, of persons already in the service of the Organization in preference to other persons from outside . This preference shall also be applied, on a reciprocal basis, to the United Nations and specialized agencies brought into relationship with the United Nations.
STAFF REGULATIONS – ARTICLE IX Separation from Service	STAFF REGULATIONS – ARTICLE IX Separation from Service
...	...
9.2 The Director-General may terminate the appointment of a staff member in accordance with the terms of his appointment, or if the necessities of the service require abolition of the post or reduction of the staff, if the services of the individual concerned prove unsatisfactory, or if he is, for reasons of health, incapacitated for further service.	9.2 The Director-General may terminate the appointment of a staff member in accordance with the terms of his appointment, or if the necessities of the service require abolition of the post or reduction of the staff, if the services of the individual concerned staff member prove unsatisfactory, if he refuses, or fails to take up, a reasonable reassignment or if he is, for reasons of health, incapacitated for further service.

Existing text**STAFF RULES****SALARY DETERMINATION**

320.3 On reduction in grade of a staff member with a continuing or fixed-term appointment:

320.3.1 due to reasons other than unsatisfactory performance, unsuitability for international service, or misconduct, the net base salary of a staff member shall be fixed at that step in the lower grade that corresponds to his current net base salary, or at the step nearest below if there is no exactly corresponding step;

320.3.2 due to unsatisfactory performance, unsuitability for international service, or misconduct, the net base salary may be fixed at a lower step in the lower grade.

410. RECRUITMENT POLICIES

410.4 Posts below the level of director, other than those of a short-term nature, which become vacant shall normally be announced to the staff if they represent a promotional opportunity for any staff, and selection for such posts shall normally be on a competitive basis. These requirements shall not apply to any post which it is in the interest of the Organization to fill by reassignment of a staff member without promotion.

NEW SECTION**Proposed text****STAFF RULES****SALARY DETERMINATION**

320.3 On reduction in grade of a staff member with a continuing or fixed-term appointment:

320.3.1 **due to reasons related to mobility pursuant to the Organization's mobility policy or reassignment further to Staff Rule 1050, the net base salary of a staff member shall remain, on a personal basis, at the grade and step held before the staff member was reassigned to a lower graded post further to mobility or Staff Rule 1050;**

320.3.2 due to unsatisfactory performance, unsuitability for international service, or misconduct, the net base salary may be fixed at a lower step in the lower grade;—or

~~320.3.43 due to any other reasons other than unsatisfactory performance, unsuitability for international service, or misconduct, the net base salary of a staff member shall be fixed at that step in the lower grade that corresponds to his current net base salary, or at the step nearest below if there is no exactly corresponding step.~~

410. RECRUITMENT POLICIES

410.4 **Rotational posts, as determined by the Director-General, held by staff members on continuing or fixed-term appointments in the professional category, including at director level,** ~~Posts below the level of director, other than those of a short-term nature, which become vacant~~ shall normally be **filled by the reassignment of a staff member under the Organization's mobility policy.** ~~announced to the staff if they represent a promotional opportunity for any staff, and selection for such posts shall normally~~ These requirements shall not apply to any post which it is in the interest of the Organization to fill by reassignment of a staff member without promotion.

515. MOBILITY

515.1 Further to Staff Regulation 1.2 and Staff Rule 510.1, staff members on continuing or fixed-term appointments in the professional category, including at director level, other than those on secondment to the Organization, may be subject to reassignment through a mobility exercise conducted by a global mobility committee under conditions established by the Director-General.

Existing text**Proposed text**

515.2 Staff members whose posts have been abolished and who are eligible to participate in a reassignment process pursuant to Staff Rule 1050 shall be given preference for vacancies during the mobility exercise.

NEW SECTION**1072. REFUSAL OF REASSIGNMENT**

1072.1 If a staff member refuses, or fails to take up, a reasonable reassignment, the staff member's appointment shall be terminated with three months' notice.

1072.2 Staff members whose appointments are terminated under Staff Rule 1072.1 are eligible for an indemnity pursuant to the schedule in Staff Rule 1050.10.

ANNEX 4

Strategic budget space allocation¹

[EB136/35, Annex – 9 January 2015]

REPORT OF THE WORKING GROUP ON STRATEGIC BUDGET SPACE ALLOCATION

BACKGROUND

1. The Working Group on Strategic Budget Space Allocation was established in line with the Executive Board's decision made during its 134th session. At the twentieth meeting of the Programme, Budget and Administration Committee, members of the Working Group presented the report contained in document EBPBAC20/5.
2. The Working Group presented its initial deliberations on scope, principles and criteria for a new strategic resource allocation methodology. It also presented proposed criteria for the four operational segments for the Committee's discussion and comments.
3. The Working Group recognized that the development of a new strategic resource allocation methodology in WHO is quite complex and interdependent with many other WHO reform initiatives that are currently under way, such as the work on bottom-up planning, costing of outputs and deliverables, the roles and functions of the three levels of the Organization, and the review of the financing of administrative and management costs.
4. The members of the Working Group highlighted the importance of ensuring that development of the strategic resource allocation methodology is informed by the work of these initiatives, and vice versa. They explained that the work needs to continue, given its complexity and the inter-linkages with a number of WHO initiatives that are under way.
5. Member States welcomed the report, including the road map, and expressed appreciation for the efforts of the Working Group. Member States also agreed to modify the title of the initiative from "strategic resource allocation" to "strategic budget space allocation".
6. The Executive Board, having considered the recommendation of the Programme, Budget and Administration Committee that the membership of the Working Group on Strategic Budget Space Allocation remain unchanged in order to facilitate the continuation of its work,
 - (1) decided on an exceptional basis to maintain the current membership of the Working Group on Strategic Budget Space Allocation, namely, Belgium, Cameroon, Egypt, Malaysia, Maldives and Mexico;

¹ See decision EB136(5).

(2) requested that the Programme, Budget and Administration Committee report to the Executive Board at its 136th session, including on the outcome of the deliberations of the Working Group on Strategic Budget Space Allocation.

7. At the Sixty-seventh World Health Assembly in May 2014, Member States agreed that more analysis and in-depth discussion were needed, and endorsed the road map towards the development of a proposed strategic budget space allocation methodology to be considered by the Executive Board in January 2015.¹

8. On 12 and 13 November 2014, the Working Group held its second face-to-face meeting with the objective of reaching an agreement on an approach to a strategic budget space allocation methodology, and of developing recommendations for the consideration of the Executive Board.

9. Feedback from discussions on strategic budget space allocation held during recent regional committees, and presentations by the Secretariat on planning, budgeting and financing, and the cost of administration and management, advised the deliberations of the Working Group over the course of the two-day meeting.

10. This report outlines the outcome of the Working Group's deliberations and elaborates on the methodology it is proposing for consideration by the Executive Board.

STRATEGIC BUDGET SPACE ALLOCATION METHODOLOGY

11. The Working Group's aim was to identify an objective and transparent approach to determining strategic budget space allocation based on guiding principles and the needs, priorities and results identified through the General Programme of Work, and bottom-up planning.

12. The Working Group reiterated its agreement with the current breakdown of the segments and the guiding principles previously set out for this process. It emphasized that the new strategic budget space allocation methodology must be informed by WHO reform initiatives that are currently under way, and vice versa, and therefore that the proposed methodology would be a prototype, to be evaluated and improved, as needed.

13. The Working Group highlighted that strategic budget space allocation should be flexible to allow for allocation and reallocation of budget space, and should be based on the best available data. It also recommended that the proportion of budget space allocation among the segments should be revisited in the future in the context of ongoing WHO reforms.

14. For the purpose of this exercise, the Working Group used the breakdown for the Programme budget 2014–2015 as background information for its discussions on each segment, as shown in Table 1 below.

¹ See document WHA67/2014/REC/3, summary record of third meeting of Committee A of the Sixty-seventh World Health Assembly, section 2.

Table 1. Programme budget 2014–2015 broken down by operational segment and level of Organization (%)

Based on planned costs

Operational segments	Headquarters	Regional offices	Country offices	Total
1. Country level technical cooperation	0	0	23	23
2. Provision of global and regional goods	20	13	0	33
3. Management and administration	11	6	5	22
4. Response to emergency events, such as outbreak and crisis response	1	1	20	22
Total	32	20	48	100

Scope

15. The strategic budget space allocation methodology is applied to allocate both assessed and voluntary contributions in an integrated manner and in support of the Organization's one work plan and one budget (programme budget).

Guiding principles

16. The following overarching principles guided the development of, and could continue to guide the implementation of, the new strategic budget space allocation methodology:

- ***based on needs and evidence:*** strategic budget space allocation should support those countries in greatest need and should be based on the best available data, including research findings and scientifically validated data, as well as objectively measurable benchmarks;
- ***results-based management:*** strategic budget space allocation should include robust bottom-up planning and realistic costing of outputs and deliverables, in alignment with priorities identified in the General Programme of Work and taking into consideration how and where best to allocate resources in order to achieve significant impact and value for investment;
- ***fairness and equity:*** strategic budget space allocation among geographical or functional segments should be conducted in accordance with objective and generally accepted and consistently applied criteria;
- ***accountability and transparency:*** these should be central to planning and strategic allocation of budget space and to reporting on the use of resources;
- ***clear roles and functions:*** at all three levels of the Organization, these should support decisions on allocation of tasks and budget space and strengthen accountability;
- ***performance improvement:*** this should be considered in budget space allocation to encourage delivery of results and achievement of outcomes.

Criteria by operational segment

17. The strategic budget space allocation methodology is divided into four operational segments.* Criteria and an approach for strategic budget space allocation were determined for each operational segment, and underpin the proposed methodology model.

Segment 1: Technical cooperation at country level

18. This segment relates to functions and activities at country level, where the benefits are experienced directly by individual countries. Activities could include building country capacity, providing technical support, conducting policy dialogue, adapting guidelines and strengthening systems to collect, analyse and disseminate data. Table 2 below provides the breakdown of activity and staff costs in the Programme budget 2014–2015 for segment 1.

Table 2. Segment 1: Programme budget 2014–2015 – breakdown of activity and staff costs (%)

Planned budget 2014–2015	
Activity costs	65
Staff costs	35

19. In order to determine budget space allocation for technical cooperation at the country level, two steps were suggested. The first step is to determine the aggregated budget space allocation at the regional level based on a methodology described in paragraphs 20–25 below, and the second step is to allocate budget space to support technical cooperation at the country level based on bottom-up planning and taking into account key criteria, as set out in paragraph 28 below.

20. A four-step process was used to determine the allocation at the regional level. This process consisted of (i) indicator scaling; (ii) grouping countries into deciles; (iii) generating country weightings; and (iv) generating regional allocations. A description of the methodology can be found in the Appendix.

21. The Working Group considered a number of models with different formulations of indicators, the advantages and disadvantages of each indicator, and model formulation. The indicators considered included:

- GDP per capita (PPP\$) (purchasing power parity);
- life expectancy;
- DPT3 (diphtheria, pertussis and tetanus vaccine) coverage;
- Births in the presence of skilled attendants;
- Total disability-adjusted life years (DALYs) per capita; DALYs due to communicable, maternal, perinatal and nutritional conditions per capita; DALYs due to noncommunicable diseases and injuries per capita;

* See document EB134/10.

- PPP\$ exchange rate relative to US\$ exchange rate;
- percentage of population living in urban areas; population density; road density;
- percentage of population who faced droughts, floods and extreme temperatures;
- implementation of International Health Regulations (2005); and
- Gini coefficient of income inequality.

A more detailed explanation of the methodology, including advantages and disadvantages of the indicators and the composite models formulated, can be found in the Appendix.

22. Table 3 below provides a snapshot of the percentage allocations by region for each composite model the Working Group considered.

Table 3. Segment 1: percentage allocations by region for each composite model considered (%)

WHO region	Planned budget 2014–2015	Average from 2006 validation mechanism	Composite model 1(B) ¹	Composite model 2(S) ²	Composite model 3(T) ³	Composite model 4 (U) ⁴	Composite model 5(V) ⁵
Africa	43.00	47.67	42.53	45.00	45.70	44.31	44.87
The Americas	8.00	10.24	11.15	13.35	12.48	10.78	10.16
Eastern Mediterranean	15.00	10.45	13.96	10.97	10.22	11.67	13.69
Europe	5.00	11.86	10.81	13.61	14.91	16.67	12.51
South-East Asia	16.00	10.44	12.74	7.89	7.74	8.61	10.84
Western Pacific	14.00	9.34	8.81	9.91	8.95	7.96	7.92

1 Indicators considered: GDP per capita PPP\$; life expectancy; births in the presence of skilled attendants; DPT3 vaccine coverage

2 Indicators considered: GDP per capita PPP\$; births in the presence of skilled attendants; DPT3 vaccine coverage; total DALYs; price level; population density; Gini coefficient

3 Indicators considered: GDP per capita PPP\$; births in the presence of skilled attendants; DPT3 vaccine coverage; DALYs due to communicable, maternal, perinatal and nutritional conditions; DALYs due to noncommunicable diseases and injuries; price level; population density; Gini coefficient

4 Indicators considered: GDP per capita PPP\$; births in the presence of skilled attendants; DPT3 vaccine coverage; total DALYs; price level; population density

5 Indicators considered: GDP per capita PPP\$; births in the presence of skilled attendants; DPT3 vaccine coverage; total DALYs; population density

23. After discussing the merits of each of the indicators, the Working Group considered a number of composite models made up of several of these indicators. It subsequently identified a composite model that included those indicators with the most stable, statistically robust and broadly available data as the best fit for segment 1.

24. The Working Group members were in favour of composite model 5 on the basis of data availability and the stability of its indicators, which are GDP per capita PPP\$; births in the presence of skilled attendants; DPT3 vaccine coverage; total DALYs; and population density. A few members indicated their preference for other composite models, such as model 1 (B), which has fewer indicators and provides a more proportionate distribution of budget space allocation across regions.

25. The Working Group proposes a transition period for the implementation of the proposed model by limiting the shift in the budget space allocation to no more than 2% per biennium, using the Programme budget 2014–2015 regional budget space allocations for segment 1 as the starting point. This will help the regions adjust over a period of time to a new level of budget space allocation.

26. The key factors the Working Group considered in its deliberations on strategic budget space allocation were the availability of quality data, and the recognition that countries differ with respect to their individual contexts, levels of development, resource capacity, and health needs.

27. The Working Group acknowledged the need to demonstrate performance improvements in the use of resources over time, but recognized the challenges some regions face in demonstrating quality of services when they are still struggling with the quantity of services delivered or available. It was suggested that the regions share best practices in performance improvement in order to demonstrate that resources are well spent, and that the outcomes and programmes justify the costs. Therefore, the strategic budget space allocation should be considered both at the global level among major offices and within the regions.

28. To further allocate budget space from the regional level to support technical cooperation at the country level, it is recommended to take into account:

- the needs and priorities of the individual country as part of bottom-up planning;
- alignment with the country cooperation strategy and national investment plan;
- the comparative advantage of WHO; and
- alignment with the priorities identified in the General Programme of Work.

Segment 2: Provision of global and regional goods

29. This segment covers the functions and programmes performed by WHO at headquarters and in the regional offices, as stated in Article 2 of the Constitution of the World Health Organization, for the benefit of all Member States and in support of the entire Organization. Examples of deliverables include WHO's norms, standards, policies, guidelines, analysis, and management and dissemination of health information.

30. Table 4 below provides the breakdown of activity and staff costs in the Programme budget 2014–2015 for segment 2.

Table 4. Segment 2: Programme budget 2014–2015 – breakdown of activity and staff costs (%)

Planned budget 2014–2015	
Activity costs	38
Staff costs	62

31. The Working Group recognized that segment 2 is largely based on governing body resolutions and international commitments and priorities in international public health as outlined in the General Programme of Work, and in conformity with other WHO reform initiatives that are currently under way. Therefore, it is recommended that strategic budget space allocation follow current practice and be based on the assessment and identification of global and regional health needs and priorities, taking account of the following criteria:

- the priorities identified in the General Programme of Work;
- the needs and priorities of countries;
- resolutions adopted by WHO's governing bodies;
- the comparative advantage of WHO;
- the roles and functions of the three levels of the Organization (with consideration given to efficiency and effectiveness);
- realistic costing of outputs and deliverables; and
- a project management approach.

Segment 3: Administration and management

32. This segment relates to the functions required to run the Organization. Administration and management costs can be subsumed under two general categories:

- stewardship and governance: all the corporate services and enabling functions, comprising leadership, general management and governance; and
- infrastructure and administrative support: comprising the running costs of the premises, maintenance, information technology, security and other administration support services. Most of these costs are within category 6 of the Twelfth General Programme of Work, 2014–2019, but some fall within the technical categories 1 to 5.

33. Table 5 below provides the breakdown of activity and staff costs in the Programme budget 2014–2015 for segment 3.

Table 5. Segment 3: Programme budget 2014–2015 – breakdown of activity and staff costs (%)

Planned budget 2014–2015	
Activity costs	25
Staff costs	75

34. The Working Group recognized the high fixed-cost component associated with segment 3, notably for stewardship and governance (for example, the costs of governing body meetings and governance structures, or senior management staffing across the Organization). It also acknowledged that a great deal of work had been undertaken to streamline cost harmonization and cost efficiency with respect to the administration and management functions.

35. Therefore, the Working Group recommends that the current approach to budget space allocation for the administration and management functions be maintained until the WHO reform process is completed, with consideration given to dividing leadership and governance, and administration and management into subcategories within the segment.

36. In addition, cost efficiency measures should be built into the system as an ongoing practice and should be institutionalized across the Organization to ensure that WHO achieves and demonstrates a return on investment.

37. It is also proposed that regular reporting to the Programme, Budget and Administration Committee on cost-efficiency measures and savings be instituted.

Segment 4: Response to emergency events, such as outbreak and crisis response

38. This segment covers outbreak and crisis response and polio eradication. Owing to the nature of outbreak and crisis response, which is governed by acute events, the resource requirements are normally significant but difficult to predict during the budget planning process. Polio eradication is currently considered to be a programmatic emergency for global public health, and as such, there needs to be flexibility for budget increases at short notice in order to accommodate programmatic needs.

39. Table 6 below provides the breakdown of activity and staff costs in the Programme budget 2014–2015 for segment 4.

Table 6. Segment 4: Programme budget 2014–2015 – breakdown of activity and staff costs (%)

Planned budget 2014–2015	
Activity costs	78
Staff costs	22

40. The Working Group agreed that a methodology for polio eradication already exists through the Polio Eradication and Endgame Strategic Plan 2013–2018. Therefore, the Working Group did not recommend a new approach to budget space allocation for polio eradication.

41. It is proposed that the creation of a global revolving fund be explored to address health emergencies of international concern, while taking into consideration other existing financial mechanisms within the United Nations system. Regional emergency funds should also be in place to respond to emergencies within each region.

General recommendations:

42. Within the context of the development of a methodology for strategic budget space allocation, the Working Group discussed several issues related to WHO reform. As a result, the Working Group proposes the following recommendations for the Board's consideration.

- The Secretariat continues to strengthen results-based planning and budgeting, including the improvement of transparency, efficiency, effectiveness and accountability.
- Governance reform is further advanced, in particular regarding the definition of the roles and functions of the three levels of the Organization, in order to better align the budget space allocation to roles and functions of the three levels of the Organization and to better respond to the priorities established in the programme budget.

43. The Secretariat better illustrates in the programme budget information that is factored into planning and budgeting processes, including resolutions and WHO's other global commitments.

[The Appendix presented the methodology for budget space allocation for segment 1.]

ANNEX 5

Text of the amended Statutes of the State of Kuwait Health Promotion Foundation¹

[EB136/41, Section 5 – 31 January 2015]

Article 4

Purpose

The purpose of the Foundation is to award a prize (“His Highness Sheikh Sabah Al-Ahmad Al-Jaber Al-Sabah Prize for Research in Health Care for the Elderly and in Health Promotion”) to a person or persons, an institution or institutions or a nongovernmental organization or organizations, who have made an outstanding contribution to research in the areas of health care for the elderly and in health promotion. The specific criteria that shall be applied in the assessment of the work done by the candidate/candidates shall be determined by the Foundation Selection Panel.

Article 8

The Prize

1. The Prize shall consist of a certificate of award and a sum of money, together with a plaque from the Founder, which shall be awarded not more often than once in each year, derived from the interest on the Foundation’s capital and unutilized cumulative revenues, which may be supplemented by the Founder. The sum of money initially determined may be adjusted from time to time by the Selection Panel, based on the changes in the capital of the Foundation, variation in interest rates and other relevant factors.
2. If the Prize is awarded to more than one person, an institution or institutions, or a nongovernmental organization or organizations, the sum of money shall be proportionately distributed between them.

Article 11

Revision of the Statutes

On the proposal of one of its members, the Foundation Selection Panel may propose the revision of the present Statutes. Any such proposal, if endorsed by a majority of the members of the Selection Panel, shall be submitted to the Executive Board for approval.

¹ See decision EB136(11).

ANNEX 6

Follow-up to the 2014 high-level meeting of the United Nations General Assembly to undertake a comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases¹

[EB136/11 – 24 November 2014]

1. Representatives of 63 Member States attended the high-level meeting of the United Nations General Assembly to undertake a comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases (New York, 10 and 11 July 2014), with the participation of ministers and representatives of governments. Pursuant to United Nations General Assembly resolution 68/271 on the scope and modalities of the comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases, the aim of the high-level meeting was to take stock of the progress made in implementing the commitments made by Heads of State and Governments, which were set out in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (hereafter called the Political Declaration).² The high-level meeting also aimed to identify and address gaps and reaffirm the political commitment in response to the challenges of noncommunicable diseases.
2. The outcome document of the 2014 high-level meeting (hereafter called the outcome document),³ adopted by the United Nations General Assembly in resolution 68/300, sets out continued and increased efforts that are essential in order to realize the road map of commitments included in the Political Declaration. Paragraph 30 includes a number of time-bound measures to be implemented by Member States by 2015 and 2016. The United Nations Secretary-General and the Director-General will submit a report on progress to the United Nations General Assembly in 2017, which will serve as input to a third high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases, in 2018.
3. The present report responds to the Health Assembly's agreement, in May 2014, to request the Director-General to report to the Sixty-eighth World Health Assembly on the role of WHO in the follow-up to the high-level meeting in 2014.⁴

¹ See decision EB136(13).

² Adopted by the United Nations General Assembly in resolution 66/2 (2011).

³ See [Appendix 1 to this document].

⁴ See document WHA67/2014/REC/3, summary record of seventh meeting of Committee A of the Sixty-seventh World Health Assembly, section 2.

OUTCOMES OF THE HIGH-LEVEL MEETING IN 2014

Context

4. The Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, adopted in September 2011 by Heads of State and Government,¹ included a road map of concrete commitments, with a time-bound commitment to promote, establish or support and strengthen, by 2013, as appropriate, multisectoral national policies and plans for the prevention and control of noncommunicable diseases. The Political Declaration also requested WHO to complete several global assignments that translate the vision rooted in the landmark global strategy for the prevention and control of noncommunicable diseases² and the road map of commitments contained in the Political Declaration into practical guidelines and actions to support Member States in their national efforts. The Political Declaration also called for a comprehensive review and assessment in 2014 of the progress achieved in the prevention and control of noncommunicable diseases.

National commitments

5. The outcome document of the 2014 high-level meeting recognized the remarkable progress achieved at the national level since September 2011, including an increase in the number of countries that had an operational national noncommunicable disease policy with a budget for implementation, from 32% of countries in 2010 to 50% of countries in 2013.

6. Recognizing also that progress in the prevention and control of noncommunicable diseases has been insufficient and highly uneven, and that continued and increased efforts are essential, in paragraph 30 of the outcome document ministers committed themselves to prioritize a set of measures in four priority areas: governance, prevention and reduction of risk factors, health care and surveillance. In particular, the outcome document includes, inter alia, four time-bound measures, which ministers have committed themselves to prioritize by 2015 and 2016:

- By 2015, consider setting national targets for 2025 and process indicators based on national situations, taking into account the nine voluntary global targets for noncommunicable diseases;³
- By 2015, consider developing or strengthening national multisectoral policies and plans to achieve the national targets by 2025, taking into account the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020;⁴
- By 2016, as appropriate, reduce risk factors for noncommunicable diseases and underlying social determinants through the implementation of interventions and policy options to create health-promoting environments, building on guidance set out in Appendix 3 to the global action plan;⁵

¹ United Nations General Assembly resolution 66/2.

² Resolution WHA53.17.

³ In accordance with the commitment from Ministers and representatives of States and Governments and heads of delegations included in paragraph 30(a)(i) of United Nations General Assembly resolution 68/300.

⁴ In accordance with the commitment from Ministers and representatives of States and Governments and heads of delegations included in paragraph 30(a)(ii) of United Nations General Assembly resolution 68/300.

⁵ In accordance with the commitment from Ministers and representatives of States and Governments and heads of delegations included in paragraph 30(b) of United Nations General Assembly resolution 68/300.

- By 2016, as appropriate, strengthen and orient health systems to address the prevention and control of noncommunicable diseases and underlying social determinants through people-centred primary health care and universal health coverage throughout the life cycle, building on guidance set out in Appendix 3 to the global action plan.¹

International commitments

7. In relation to the global assignments given to WHO in the Political Declaration, the outcome document welcomed:

- the adoption by the Sixty-sixth World Health Assembly of the comprehensive global monitoring framework, including the set of nine voluntary global targets for achievement by 2025 and a set of 25 indicators to be applied across regional and country settings in order to monitor trends and assess progress made in the implementation of national strategies and plans on noncommunicable diseases;²
- the endorsement by the Sixty-sixth World Health Assembly of the global action plan for the prevention and control of noncommunicable diseases 2013–2020² and the approval by the Sixty-seventh World Health Assembly of the nine indicators to inform reporting on progress made in implementing the global action plan;³
- the establishment of the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases and the endorsement of its terms of reference by the United Nations Economic and Social Council on 13 June 2014;⁴
- the agreement by the Sixty-seventh World Health Assembly to endorse the terms of reference of the global coordination mechanism on the prevention and control of noncommunicable diseases and to note its work plan covering the period 2014–2015.³

8. Recognizing the need to continue to strengthen international cooperation in the prevention and control of noncommunicable diseases, ministers committed themselves in the outcome document to invite the OECD's Development Assistance Committee to consider developing a purpose code for noncommunicable diseases in order to improve tracking of official development assistance in support of national efforts for the prevention and control of noncommunicable diseases.⁵

¹ In accordance with the commitment from Ministers and representatives of States and Governments and heads of delegations included in paragraph 30(c) of United Nations General Assembly resolution 68/300.

² See resolution WHA66.10.

³ See document WHA67/2014/REC/3, summary record of seventh meeting of Committee A of the Sixty-seventh World Health Assembly, section 2.

⁴ See United Nations Economic and Social Council resolutions E/RES/2013/12 and E/RES/2014/10.

⁵ In accordance with the commitment from Ministers and representatives of States and Governments and heads of delegations included in paragraph 33 of United Nations General Assembly resolution 68/300.

9. With a view to strengthening the contributions from non-State actors to realize the commitments included in the Political Declaration, Ministers requested the Secretariat, in consultation with Member States, to develop, before the end of 2015, an approach that can be used to register and publish contributions of the private sector, philanthropic entities and civil society to the achievement of the nine voluntary targets for the prevention and control of noncommunicable diseases.¹

10. In preparation for a comprehensive review by the United Nations General Assembly in 2018 of the progress achieved in the prevention and control of noncommunicable diseases, Ministers requested the United Nations Secretary-General, in collaboration with Member States, WHO and relevant organizations of the United Nations system, to submit to the United Nations General Assembly, by the end of 2017, a report on the progress achieved in implementing the Political Declaration and the outcome document.²

GAPS NOT DEALT WITH BY THE HIGH-LEVEL MEETING IN 2014

11. The need to develop a set of process indicators, capable of application across country settings, to assess the progress made in the implementation of the road map of commitments included in the Political Declaration was the subject of intense discussions by Member States during the preparatory process leading towards the high-level meeting in 2014.

12. One view held that the development of such a set of process indicators would enable the United Nations Secretary-General and the Director-General to inform their reporting in 2017 to the United Nations General Assembly on the progress made in the process of implementing the Political Declaration. The indicators to inform reporting on progress made in the process of implementing the Political Declaration at national level, which the Regional Committee for the Eastern Mediterranean adopted in October 2012,³ were cited as an example.

13. Another view considered that the nine indicators to inform reporting on the progress made in the process of implementing the global action plan for the prevention and control of noncommunicable diseases 2013–2020⁴ and/or the 25 outcome indicators to measure progress achieved in attaining the nine voluntary global targets⁵ would inform reporting on the progress made to the United Nations General Assembly in 2017.

14. The absence of consensus among all Member States on this issue resulted in an outcome document that lacks guidance on how the Director-General should report to the United Nations General Assembly in 2017 on the progress achieved in implementing the Political Declaration and the outcome document. This might require further debate by the Executive Board, at its 136th session, and the Sixty-eighth World Health Assembly.

¹ In accordance with paragraph 37 of United Nations General Assembly resolution 68/300.

² In accordance with paragraph 38 of United Nations General Assembly resolution 68/300.

³ See resolution EM/RC59/R.2.

⁴ Endorsed by the Sixty-seventh World Health Assembly (see document WHA67/2014/REC/3, summary record of seventh meeting of Committee A of the Sixty-seventh World Health Assembly, section 2).

⁵ See resolution WHA66.10.

WHO'S ROLE IN THE FOLLOW-UP TO THE HIGH-LEVEL MEETING IN 2014

15. **Technical assistance provided by the Secretariat to Member States.** In order to provide technical guidance to Member States in their efforts to implement the measures set out in paragraph 30 of the outcome document, the Secretariat will publish a series of policy briefs during the first half of 2015 on each measure. These policy briefs will also serve as input to a first global conference of national noncommunicable disease focal points, which the Secretariat will convene during the second half of 2015. An electronic learning platform for policy-makers will be launched towards the end of 2015. To continue to strengthen WHO's efforts to build national capacities to tackle the high-level noncommunicable disease issues related to governance, the prevention and reduction of risk factors, health care and surveillance, the Secretariat will aim to build, within existing resources, a new model to expand its technical assistance to Member States, building on lessons learnt from projects implemented using voluntary contributions from the Russian Federation, the Bill & Melinda Gates Foundation, and Bloomberg Philanthropies. The "One-WHO Noncommunicable Disease Work Plan" (method of work), currently under development, will ensure synergies and alignment of activities across the three levels of the Organization in 2015 and beyond.

16. **Technical assistance provided by the Members of the United Nations Inter-Agency Task Force on the Prevention and Control of Noncommunicable Diseases to Member States.** Pursuant to paragraph 9 of United Nations General Assembly resolution 68/300, and in accordance with paragraph 2 of United Nations Economic and Social Council resolution E/RES/2013/12, as well as a follow-up to United Nations Economic and Social Council resolution E/RES/2014/10, the Secretariat plans to continue and strengthen its leadership and coordination role in promoting global action against noncommunicable diseases in relation to the work of other relevant organizations of the United Nations system, development banks and other international organizations in tackling noncommunicable diseases in a coordinated manner. To support Member States in their commitment to integrate measures to address noncommunicable diseases into the design process and implementation of the United Nations Development Assistance Framework,¹ WHO and UNDP will publish a guidance note in early 2015. To support governments in their national efforts to tackle noncommunicable diseases, the Members of the Inter-Agency Task Force will continue to field six joint technical assistance missions in 2015, building on the outcomes of three missions carried out in 2014. To support national efforts in using mobile technologies to tackle noncommunicable diseases, the Secretariat will aim to expand the technical assistance provided under the ITU/WHO Global Joint Programme on mHealth and noncommunicable diseases, entitled "Be he@lthy, be mobile".² Efforts are under way to start implementing similar global joint programmes with other organizations of the United Nations system in 2015.

17. **Facilitation and enhancement of coordination of activities, multistakeholder engagement and action across sectors.** Pursuant to paragraph 11 of United Nations General Assembly resolution 68/300 and in accordance with the agreement of the Sixty-seventh World Health Assembly to endorse the terms of reference of the global coordination mechanism on the prevention and control of noncommunicable diseases,³ the Director-General established on 15 September 2014 a separate secretariat within the office of the Assistant Director-General for Noncommunicable Diseases and

¹ In accordance with commitment from Ministers and representatives of States and Governments and heads of delegations included in paragraph 30(a)(v) of United Nations General Assembly resolution 68/300.

² See http://www.itu.int/en/ITU-D/ICT-Applications/eHEALTH/Pages/Be_Healthy_intro.aspx (accessed 27 October 2014).

³ See document WHA67/2014/REC/3, summary record of seventh meeting of Committee A of the Sixty-seventh World Health Assembly, section 2.

Mental Health to support the global coordination mechanism. In accordance with the work plan for that global coordination mechanism covering the period 2014–2015,¹ which the Sixty-seventh World Health Assembly noted,² during the fourth quarter of 2014 the secretariat for the global coordination mechanism will establish two Working Groups to recommend ways and means of encouraging Member States and non-State actors to realize the commitments included in paragraphs 44 and 45(d), respectively, of the Political Declaration. Each Working Group will meet during the first quarter of 2015 to start its work, taking into account that each Working Group's final report will be submitted to the Director-General towards the end of 2015. Work is under way to establish dialogues, web-based platforms and communities of practice during the first half of 2015. Pursuant to paragraph 15 of Appendix 1 to document A67/14 Add.1, the draft work plan for the global coordination mechanism covering the period 2016–2017 is being submitted for consideration in the accompanying document EB136/11 Add.1.

18. Development of an approach that can be used to register and publish contributions of non-State actors to the achievement of the nine voluntary global targets for the prevention and control of noncommunicable diseases. Pursuant to paragraph 37 of United Nations General Assembly resolution 68/300, the Secretariat will develop, before the end of 2015, in consultation with Member States, an approach that can be used to register and publish contributions of the private sector, philanthropic entities and civil society to the achievement of the nine voluntary targets for the prevention and control of noncommunicable diseases. To this end, during the second quarter of 2015 the Secretariat aims to publish a first discussion paper outlining a proposed approach for a web-based consultation, to be followed by the publication of a second discussion paper during the third quarter of 2015, which will serve as an input into a consultation with Member States during the fourth quarter of 2015 to complete the work.

19. Development of a Framework for Country Action to engage sectors beyond health. Pursuant to paragraph 10 of United Nations General Assembly resolution 68/300 and in accordance with subparagraph 3(1) of resolution WHA67.12, the Secretariat will prepare, for the consideration of the Sixty-eighth World Health Assembly, in consultation with Member States, organizations of the United Nations system and other international organizations, and within existing resources, a Framework for Country Action, for adaptation to different contexts, taking into account the Helsinki Statement on Health in All Policies. To this end, during the fourth quarter of 2014 the Secretariat will publish a first discussion paper outlining the proposed framework for country action for a web-based consultation. The outputs of the web-based consultation will serve as an input into the final draft, which the Secretariat will submit to the Sixty-eighth World Health Assembly.

¹ Contained in document A67/14 Add.3 Rev.1.

² See document WHA67/2014/REC/3, summary record of seventh meeting of Committee A of the Sixty-seventh World Health Assembly, section 2.

20. **Updating the menu of policy options and cost-effective interventions for the prevention and control of noncommunicable diseases to assist Member States in implementing actions to achieve the nine voluntary global targets.** Pursuant to paragraphs 15, 24, 30(b) and 30(c) of United Nations General Assembly resolution 68/300, and in accordance with subparagraph 3(10) of resolution WHA66.10, the Secretariat will conduct a review of evidence in 2015 to propose an update of Appendix 3 to the global action plan for the prevention and control of noncommunicable diseases 2013–2020 in light of new scientific evidence, and to submit a proposed update of Appendix 3 to the Sixty-ninth World Health Assembly, in 2016, through the Executive Board. The review of evidence in 2015 will include systematic reviews, where appropriate.

21. **Updating the WHO global status reports on noncommunicable diseases.** Action 39(e) of the action plan for the global strategy for the prevention and control of noncommunicable diseases 2008–2013 and action 60(b) of the global action plan for 2013–2020 request the Secretariat to publish global status reports on the prevention and control of noncommunicable diseases in 2014, 2016 and 2021, describing trends in noncommunicable diseases and risk factors and countries' capacity to respond, and providing policy guidance for the prevention and control of noncommunicable diseases, similar to the first WHO global status report on noncommunicable diseases in 2010.¹ The second global status report is being prepared and is expected to be published during the first quarter of 2015. It will include data on mortality and risk factors in 2010, providing a global baseline against which progress will be measured towards attaining the nine voluntary global targets by 2025. It will also set out the latest statistics, evidence and experiences needed to support Member States in launching a forceful response to meet the time-bound commitments included in paragraph 30 of the outcome document.

22. **Reporting progress to the Health Assembly.** As requested in subparagraph 3(9) of resolution WHA66.10, the Secretariat will submit reports on progress made in implementing the global action plan for the prevention and control of noncommunicable diseases 2013–2020, through the Executive Board, to the Health Assembly in 2016, 2018 and 2021. In accordance with action 60(b) of the global action plan for the prevention and control of noncommunicable diseases 2013–2020, the Secretariat will conduct an independent evaluation of the implementation of the action plan in 2017 and 2020, and include its findings in these progress reports. The Secretariat will also submit reports on progress achieved in attaining the nine voluntary global targets in 2016, 2021 and 2026. These progress reports will include the outcomes of the WHO surveys to assess national capacity for the prevention and control of noncommunicable diseases, which will be conducted in 2015, 2017 and 2019.

23. **Reporting progress to the United Nations Economic and Social Council.** As requested in paragraph 3 of United Nations Economic and Social Council resolution E/RES/2014/10, the Secretariat will prepare a report for the United Nations Secretary-General on the implementation of United Nations Economic and Social Council resolution E/RES/2013/12, which the United Nations Secretary-General will submit for the consideration of the Economic and Social Council at its 2015 session.

24. **Reporting progress to the United Nations General Assembly.** As requested in paragraph 38 of United Nations General Assembly resolution 68/300, the Secretariat will prepare a report, in 2017, on the progress achieved in the implementation of the outcome document and the Political Declaration, in collaboration with Member States and relevant organizations of the United Nations system.

¹ Global status report on noncommunicable diseases 2010. Geneva: World Health Organization; 2010.

25. **Preparatory process for the third high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases.** As part of the preparatory process for the third high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases, and building on the successful outcomes of the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control (Moscow, 28 and 29 April 2011), which served as a key input for the preparations leading to the first high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases,¹ the Secretariat is exploring the possibility of convening a second global ministerial conference on healthy lifestyles and noncommunicable disease control in 2016.

26. A table summarizing the sequencing of reports and evaluations listed in paragraphs 15 to 25 of this report is set out in [Appendix 2 to this document].

ACTION BY THE EXECUTIVE BOARD

27. [In this paragraph the Board was invited to note the report and provide further guidance on the possible need to develop a set of process indicators, capable of application across country settings, to assess the progress made in the implementation of the road map of commitments included in the Political Declaration and the prioritized commitments in the outcome document, with a view to inform reporting in 2017 by the Director-General to the United Nations General Assembly on progress made.]

APPENDIX 1

OUTCOME DOCUMENT OF THE HIGH-LEVEL MEETING OF THE UNITED NATIONS GENERAL ASSEMBLY ON THE COMPREHENSIVE REVIEW AND ASSESSMENT OF THE PROGRESS ACHIEVED IN THE PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES

Resolution 68/300 adopted by the United Nations General Assembly on 10 July 2014.

The General Assembly

Adopts the following outcome document:

Outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases

We, Ministers and representatives of States and Governments and heads of delegations, assembled at the United Nations on 10 and 11 July 2014 to take stock of the progress made in implementing the commitments set out in the political declaration of the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, adopted by the General Assembly in its resolution 66/2 of 19 September 2011,

¹ See resolution WHA64.11.

Intensifying our efforts towards a world free of the avoidable burden of non-communicable diseases

1. Reaffirm the political declaration, which has catalysed action and retains great potential for engendering sustainable improved health and human development outcomes;
2. Reaffirm our commitment to address the global burden and threat of non-communicable diseases, which constitute one of the major challenges for development in the twenty-first century, undermine social and economic development throughout the world, threaten the achievement of internationally agreed development goals and may lead to increasing inequalities within and between countries and populations;
3. Reiterate that the most prevalent non-communicable diseases, namely, cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, are primarily linked to four common risk factors, namely, tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity;
4. Reiterate our concern regarding the rising levels of obesity in different regions, particularly among children and youth;
5. Recognize that mental and neurological conditions are an important cause of morbidity and contribute to the global non-communicable disease burden, in respect of which there is a need to provide equitable access to effective programmes and health-care interventions, as described in the comprehensive mental health action plan 2013–2020 of the World Health Organization;¹
6. Recall the Moscow Declaration, adopted at the first Global Ministerial Conference on Healthy Lifestyles and Non-communicable Disease Control, held in April 2011,² as well as 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;

Taking stock: progress achieved since 2011

7. Welcome the development by the World Health Organization, in accordance with paragraph 61 of the political declaration, of the comprehensive global monitoring framework, including the set of 9 voluntary global targets for achievement by 2025 and a set of 25 indicators to be applied across regional and country settings in order to monitor trends and assess progress made in the

¹ World Health Organization, document WHA66/2013/REC/1.

² A/65/859, annex.

implementation of national strategies and plans on non-communicable diseases, and the adoption of the framework by the World Health Assembly;

8. Also welcome the endorsement by the World Health Assembly of the Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013–2020¹ and its adoption of the nine indicators to inform reporting on progress made in implementing the Global Action Plan;

9. Welcome the establishment of the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases and the endorsement of its terms of reference by the Economic and Social Council on 13 June 2014;

10. Welcome the request that the Director General of the World Health Organization prepare, for consideration during the sixty-eighth World Health Assembly, in consultation with Member States, United Nations organizations and other relevant stakeholders, as appropriate, and within existing resources, a framework for country action, for adaptation to different contexts, taking into account the Helsinki Statement on Health in All Policies, adopted at the Eighth Global Conference on Health Promotion, aimed at supporting national efforts to improve health, ensure health protection, health equity and health system functioning, including through action across sectors on determinants of health and risk factors of non-communicable diseases, based on best available knowledge and evidence;

11. Also welcome the endorsement by the World Health Assembly of the terms of reference for the comprehensive global coordination mechanism for the prevention and control of non-communicable diseases;

12. Recognize the remarkable progress achieved at the national level, since September 2011, including an increase in the number of countries which have an operational national non-communicable disease policy with a budget for implementation, from 32 per cent of countries in 2010 to 50 per cent of countries in 2013;

13. Recognize that progress in the prevention and control of non-communicable diseases has been insufficient and highly uneven, due in part to their complexity and challenging nature, and that continued and increased efforts are essential for achieving a world free of the avoidable burden of non-communicable diseases;

14. Acknowledge that, despite some improvements, commitments to promote, establish or support and strengthen, by 2013, multisectoral national policies and plans for the prevention and control of non-communicable diseases, and to increase and prioritize budgetary allocations for addressing non-communicable diseases, were often not translated into action, owing to a number of factors, including the lack of national capacity;

15. Acknowledge that many countries, in particular developing countries, are struggling to move from commitment to action and, in this regard, reiterate our call upon Member States to consider implementing, as appropriate, within national contexts, policies and evidence-based, affordable, cost-effective, population-wide and multisectoral interventions, including a reduction of modifiable risk factors of non-communicable diseases as described in appendix 3 to the Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013–2020;

¹ World Health Organization, document WHA66/2013/REC/1.

16. Recognize that affordable interventions to reduce environmental and occupational health risks are available and that prioritization and implementation of such interventions in accordance with national conditions can contribute to reducing the burden of non-communicable diseases;

17. Reiterate our call upon Member States to consider implementing, as appropriate, according to national circumstances, policy options and cost-effective, affordable, multisectoral interventions for the prevention and control of non-communicable diseases¹ in order to achieve the nine voluntary global targets for non-communicable diseases by 2025;

Reaffirming our leadership: commitments and actions

18. Reaffirm our commitment to advance the implementation of multisectoral, cost-effective, population-wide interventions in order to reduce the impact of the four common behavioural risk factors for non-communicable diseases, through the implementation of relevant international agreements, strategies, national policies, legislation and development priorities, including educational, 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;

19. Recognize that the implementation of the Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013–2020, the Global Strategy on Diet, Physical Activity and Health,² the Global Strategy to Reduce the Harmful Use of Alcohol,³ the Global Strategy for Infant and Young Child Feeding of the World Health Organization and the United Nations Children's Fund, and the World Health Organization Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children,⁴ as appropriate, will accelerate efforts to reduce non-communicable diseases, and reiterate our call upon Member States to mobilize political will and financial resources for that purpose;

20. Reiterate our commitment to accelerate the implementation of the World Health Organization Framework Convention on Tobacco Control⁵ by States parties, and encourage countries to consider becoming parties to the Convention;

21. Call upon Member States to take steps, including, where appropriate, effective legislation, cross-sectoral structures, processes, methods and resources that enable societal policies which take into account and address the impacts on health determinants, health protection, health equity and health system functioning, and which measure and track economic, social and environmental determinants and disparities in health;

22. Call upon Member States to develop, as appropriate, institutional capacity with adequate knowledge and skills for assessing the impact on health of policy initiatives in all sectors, identifying solutions and negotiating policies across sectors to achieve improved outcomes from the perspective of health, health equity and health system functioning;

¹ Such as those included in appendix 3 to the annex to resolution WHA66.10.

² World Health Organization, document WHA57/2004/REC/1, resolution 57.17, annex.

³ World Health Organization, document WHA63/2010/REC/1, annex 3.

⁴ World Health Organization, document WHA63/2010/REC/1, annex 4.

⁵ United Nations, *Treaty Series*, vol. 2302, No. 41032.

23. Recognize the importance of universal health coverage in national health systems, and call upon Member States to strengthen 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 throughout the life cycle;
24. Continue to scale up, where appropriate, a package of proven, cost-effective interventions, including those identified in appendix 3 to the Global Action Plan;
25. Reiterate the importance of increased access to cost-effective cancer screening programmes as determined by national situations, as well as the importance of promoting increased access to cost-effective vaccinations to prevent infections associated with cancer, as part of national immunization schedules;
26. Acknowledge that limited progress has been made in implementing paragraph 44 of the annex to General Assembly resolution 66/2, and although an increased number of private sector entities have started to produce and promote food products consistent with a healthy diet, such products are not always broadly affordable, accessible and available in all communities within countries;
27. Continue to encourage policies that support the production and manufacture of and facilitate access to foods that contribute to a healthy diet and provide greater opportunities for the utilization of healthy local agricultural products and foods, thereby contributing to efforts to cope with the challenges and take advantage of opportunities presented by globalization and to achieve food security and adequate nutrition;
28. Reaffirm the primary role and responsibility of Governments in responding to the challenge of non-communicable diseases, including through engaging non-governmental organizations, the private sector and other sectors of society to generate effective responses for the prevention and control of non-communicable diseases at the global, national and local levels;
29. Recall that effective non-communicable disease prevention and control requires leadership and multisectoral approaches to health at the governmental level, including, as appropriate, health-in-all-policies and whole-of-government approaches across sectors beyond health, while protecting public health policies for the prevention and control of non-communicable diseases from undue influence by any form of real, perceived or potential conflict of interest;

Moving forward: national commitments

30. Commit to addressing non-communicable diseases as a matter of priority in national development plans, as appropriate within national contexts and the international development agenda, and to take the following measures with the engagement of all relevant sectors, including civil society and communities, as appropriate:

- (a) Enhance governance:

- (i) By 2015, consider setting national targets for 2025 and process indicators based on national situations, taking into account the nine voluntary global targets for non-communicable diseases, 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;

- (ii) By 2015, consider developing or strengthening national multisectoral policies and plans to achieve the national targets by 2025, taking into account the Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013–2020;
 - (iii) Continue to develop, strengthen and implement, as appropriate, multisectoral public policies and action plans to promote health education and health literacy, with a particular focus on populations with low health awareness and/or literacy;
 - (iv) Raise awareness about the national public health burden caused by non-communicable diseases and the relationship between non-communicable diseases, poverty and social and economic development;
 - (v) Integrate measures to address non-communicable diseases into health planning and national development plans and policies, including the design process and implementation of the United Nations Development Assistance Framework;
 - (vi) Consider establishing, as appropriate to the respective national context, a national multisectoral mechanism, such as a high-level commission, agency or task force for engagement, policy coherence and mutual accountability of different spheres of policymaking that have a bearing on non-communicable diseases, in order to implement health-in-all-policies and whole-of-government and whole-of-society approaches, and to monitor and act on the determinants of non-communicable diseases, including social and environmental determinants;
 - (vii) Enhance the capacity, mechanisms and mandates, as appropriate, of relevant authorities in facilitating and ensuring action across governmental sectors;
 - (viii) Strengthen the capacity of ministries of health to exercise a strategic leadership and coordination role in policy development that engages all stakeholders across government, non-governmental organizations, civil society and the private sector, ensuring that issues relating to non-communicable diseases receive an appropriate, coordinated, comprehensive and integrated response;
 - (ix) Align international cooperation on non-communicable diseases with national plans concerning non-communicable diseases in order to strengthen aid effectiveness and the development impact of external resources in support of non-communicable diseases;
 - (x) Develop and implement national policies and plans, as relevant, with financial and human resources allocated particularly to addressing non-communicable diseases, in which social determinants are included;
- (b) By 2016, as appropriate, reduce risk factors for non-communicable diseases and underlying social determinants through the implementation of interventions and policy options to create health-promoting environments, building on guidance set out in appendix 3 to the Global Action Plan;
- (c) By 2016, as appropriate, strengthen and orient health systems to address the prevention and control of non-communicable diseases and the underlying social determinants through people-centred primary health care and universal health coverage throughout the life cycle, building on guidance set out in appendix 3 to the Global Action Plan;
- (d) Consider 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;

(e) Continue to promote the inclusion of prevention and control of non-communicable diseases within programmes for sexual and reproductive health and maternal and child health, especially at the primary health-care level, as well as communicable disease programmes, such as those addressing tuberculosis, as appropriate;

(f) Consider the synergies between major non-communicable diseases and other conditions as described in appendix 1 to the Global Action Plan in order to develop a comprehensive response for the prevention and control of non-communicable diseases that also recognizes the conditions in which people live and work;

(g) Monitor the trends and determinants of non-communicable diseases and evaluate progress in their prevention and control:

(i) Assess progress towards attaining the voluntary global targets and report on the results using the indicators established in the comprehensive global monitoring framework, according to the agreed timelines, and use results from monitoring of the 25 indicators and 9 voluntary targets and other sources of data to inform and guide policy and programming, aiming to maximize the impact of interventions and investments on non-communicable disease outcomes;

(ii) Contribute information on trends in non-communicable diseases to the World Health Organization, according to the agreed timelines on progress made in the implementation of national action plans and on the effectiveness of national policies and strategies, coordinating country reporting with global analyses;

(iii) Develop or strengthen, as appropriate, surveillance systems to track social disparities in non-communicable diseases and their risk factors as a first step to addressing inequalities, and pursue and promote gender-based approaches for the prevention and control of non-communicable diseases on the basis of data disaggregated by sex, age and disability, in an effort to address the critical differences in the risks of morbidity and mortality from non-communicable diseases for women and men;

(h) Continue to 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, strengthening of health systems, training of health-care personnel and the 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 for 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;

31. Continue to strengthen international cooperation through 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;

32. Continue to explore the provision of adequate, predictable and sustained resources, through domestic, bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanisms;

Moving forward: international commitments

33. Invite the Development Assistance Committee of the Organization for Economic Cooperation and Development to consider developing a purpose code for non-communicable diseases in order to improve the tracking of official development assistance in support of national efforts for the prevention and control of non-communicable diseases;

34. Reiterate our commitment to actively promote national and international investments and strengthen national capacity for quality research and development, in all aspects relating 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 in public health, inter alia, as appropriate, through a sound and balanced intellectual property rights system, which is important, inter alia, for the development of new medicines, as recognized in the Doha Declaration on the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) and Public Health;

35. Reaffirm the right to use, to the fullest extent, the provisions contained in the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement), the Doha Declaration on the TRIPS Agreement and Public Health, the decision of the General Council of the World Trade Organization of 30 August 2003 on the implementation of paragraph 6 of the Doha Declaration, and, when formal acceptance procedures are completed, the amendment to article 31 of the TRIPS Agreement, which provide flexibilities for the protection of public health, and in particular to promote access to medicines for all and encourage the provision of assistance to developing countries in this regard;

36. Give due consideration to addressing non-communicable diseases in the elaboration of the post-2015 development agenda, taking into account, in particular, their serious socioeconomic consequences and determinants and their links to poverty;

37. Call upon the World Health Organization, in consultation with Member States, in the context of the comprehensive global coordination mechanism for the prevention and control of non-communicable diseases, while ensuring appropriate protection from vested interests, to develop, before the end of 2015, an approach that can be used to register and publish contributions of the private sector, philanthropic entities and civil society to the achievement of the nine voluntary targets for non-communicable diseases;

Towards the world we want: follow-up

38. 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 submit to the General Assembly, by the end of 2017, for consideration by Member States, a report on the progress achieved in the implementation of the present outcome document and of the political declaration of the high-level meeting of the Assembly on the prevention and control of non-communicable diseases, in preparation for a comprehensive review, in 2018, of the progress achieved in the prevention and control of non-communicable diseases.

*100th plenary meeting
10 July 2014*

APPENDIX 2

SEQUENCING OF REPORTS, SURVEYS AND EVALUATIONS

	United Nations General Assembly	United Nations Economic and Social Council	World Health Assembly			Evaluation	Status and guidance	National Noncommunicable Diseases Capacity Assessment Survey
	Report on progress	Report on the implementation of resolution E/RES/2013/12 (United Nations Inter-Agency Task Force on noncommunicable diseases)	Reports on progress made in implementing the global action plan for the prevention and control of noncommunicable diseases 2013–2020	Reports on progress made in attaining the nine voluntary global targets	Update of Appendix 3 to the global action plan for the prevention and control of noncommunicable diseases 2013–2020	Independent evaluation of the implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020	WHO global status reports on noncommunicable diseases	
2015		X					X	X
2016			X	X	X		X	
2017	X					X		X
2018	Third high-level meeting		X ←					
2019								X
2020						X		
2021			X ←	X			X	

	United Nations General Assembly	United Nations Economic and Social Council	World Health Assembly			Evaluation	Status and guidance	National Noncommunicable Diseases Capacity Assessment Survey
	Report on progress	Report on the implementation of resolution E/RES/2013/12 (United Nations Inter-Agency Task Force on noncommunicable diseases)	Reports on progress made in implementing the global action plan for the prevention and control of noncommunicable diseases 2013–2020	Reports on progress made in attaining the nine voluntary global targets	Update of Appendix 3 to the global action plan for the prevention and control of noncommunicable diseases 2013–2020	Independent evaluation of the implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020	WHO global status reports on noncommunicable diseases	
2022								
2023								
2024								
2025								
2026				X				

ANNEX 7

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

1. Resolution EB136.R1 Global technical strategy and targets for malaria 2016–2030	
2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf) Category: 1. Communicable diseases Programme area(s): Malaria	
	Outcome: 1.3. Increased access to first-line antimalarial treatment for confirmed malaria cases Outputs: 1.3.1. Countries enabled to implement malaria strategic plans, with focus on improved diagnostic testing and treatment, therapeutic efficacy monitoring and surveillance through capacity strengthening 1.3.2. Updated policy recommendations, strategic and technical guidelines on vector control, diagnostic testing, antimalarial treatment, integrated management of febrile illness, surveillance, epidemic detection and response
How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)? The resolution fully adopts the global technical strategy for malaria 2016–2030, and will enable the Secretariat to strengthen its capacity to support Member States to implement the principles and pillars described in the strategy while maintaining a robust and evidence-based policy-making process.	
Does the Programme budget already include the outputs and deliverables 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 resolution time frame is consistent with the United Nations post-2015 development agenda and many activities set out in the resolution will be ongoing.	
(ii) A process to update the programme area plan has begun in order to ensure that the three levels of the Secretariat are strengthened to have the capacity to support Member States to implement the vision articulated in the strategy. The estimates below include only the request for headquarters; the total request, including regional and country offices, will be articulated in the documentation submitted for consideration by the Sixty-eighth World Health Assembly.	
The resolution includes elements that go beyond the previously-agreed budget for malaria, particularly in supporting Member States to accelerate their national malaria programmes towards malaria elimination.	
An indicative costing for the biennium 2016–2017 currently estimates the cost of the work to be performed by the secretariat of the Global Malaria Programme at headquarters to be US\$ 33.9 million (staff: US\$ 22.6 million; activities: US\$ 11.3 million), which is US\$ 5 million above the budget currently planned for the biennium 2016–2017. It does not yet include costs incurred at regional and country levels, which will be finalized in the report on financial and administrative implications for the draft resolution to be considered by the Sixty-eighth World Health Assembly.	

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

US\$ nil (staff: US\$ nil; activities: US\$ nil).

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

Not applicable.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Not applicable.

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 Secretariat is currently updating the programme area plan and will fully articulate additional positions as a deliverable by the end of the first quarter of 2015, but initial estimates indicate the need for four full-time equivalent staff members for the remainder of the biennium 2014–2015.

4. Funding

Is the estimated cost for the biennium 2014–2015 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).

Not applicable.

1. Resolution EB136.R5 Yellow fever risk mapping and recommended vaccination for travellers**2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)**

Category: 5. Preparedness, surveillance and response

Programme area: Alert and response capacities

Programme area: Epidemic-prone and pandemic-prone diseases

Outcome:

5.1. All countries have the minimum core capacities required by the International Health Regulations (2005) for all-hazard alert and response

Output:

5.1.1. Countries enabled to develop core capacities required under International Health Regulations (2005).

How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?

It would facilitate and reinforce guidance for international travel vaccination.

Does the Programme budget already include the outputs and deliverables 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 resolution is not time-bound, with implementation involving a yearly meeting of a scientific and technical advisory group on geographical yellow fever risk mapping.

(ii) Total: US\$ 100 000 per year (cost of yearly meeting of the advisory group).

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 100 000 (cost of first meeting of the advisory group)

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 2014–2015? (Yes/no)

No.

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

US\$ 100 000.

(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 2014–2015 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\$ 100 000. It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

1. Resolution EB136.R6 The recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation

2. Linkage to the Programme budget 2014–2015 (see document A66/7
http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)

Category: 5

Programme area(s): **5.1 and 5.2**

Outcomes:

5.1. All countries have the minimum core capacities required by the International Health Regulations (2005) for all-hazard alert and response

5.2. Increased capacity of countries to build resilience and adequate preparedness to mount a rapid, predictable and effective response to major epidemics and pandemics

Outputs:

5.1.1. Countries enabled to develop core capacities required under International Health Regulations (2005)

5.2.1. Countries are enabled to develop and implement operational plans, in line with WHO recommendations on strengthening national resilience and preparedness covering pandemic influenza and epidemic and emerging diseases

How would this decision contribute to the achievement of the outcome(s) of the above programme area(s)?

This will provide impetus to the implementation of the Review Committee recommendations.

Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no)

Yes.

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

(a) Total cost

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

(i) One year (covering 2015)

(ii) Total: US\$ 2 100 000 (staff: US\$ 1 500 000; activities: US\$ 600 000)

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 2 100 000 (staff: US\$ 1 500 000; activities: US\$ 600 000)

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

Headquarters and the six regions

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

No.

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

US\$ 2 100 000 – the costs are currently not foreseen in the Programme Budget 2014–2015; however, we will reprioritize activities among the category network and request additional space if necessary.

(c) Staffing implications

Could the decision 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.

– one full-time staff, P4, one year in each region

– one full-time staff, P4, six months at headquarters

4. Funding

Is the estimated cost for the biennium 2014–2015 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\$ 2 100 000; source(s) of funds: The funding gap will be addressed through the Organization-wide coordinated resource mobilization effort.

1. Resolution EB136.R7 Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage

2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)

Category: 4. Health systems

Programme area(s): Integrated people-centred health services

Outcome: 4.2. Policies, financing and human resources are in place to increase access to integrated people-centred health services

Outputs: 4.2.1. Policy options, tools and technical support to countries for equitable people-centred integrated service delivery and strengthening of public health approaches

4.2.2. Countries enabled to plan and implement strategies that are in line with WHO's global strategy on human resources for health and the WHO Global Code of Practice on the International Recruitment of Health Personnel

4.2.3. Guidelines, tools and technical support to countries for improved patient safety and quality of services, and for patient empowerment

How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?

The resolution would support the achievement of timely, safe access to emergency and essential surgical care and anaesthesia in primary health care facilities and first referral hospitals as an integral component of universal health coverage. It would foster multisectoral networks and partnerships, multidisciplinary policies and action plans, and support national, regional and global efforts to scale up a skilled health workforce and measures for access to, and safety of, emergency and essential surgery and anaesthesia services.

Does the Programme budget already include the outputs and deliverables 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) Five years (covering the period 2014–2018).

(ii) Total: US\$ 22.98 million (staff: US\$ 10.48 million; activities: US\$ 12.50 million).

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 9.20 million (staff: US\$ 4.20 million; activities: US\$ 5.00 million).

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

Headquarters and all six regional offices.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (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.

During the biennium 2016–2017, at least one additional staff member at grade P.4 at headquarters and one at grade P.4 in each of the six regional offices would be required.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No.

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

The funding gap is US\$ 2.98 million for the period from May to December 2015 inclusive (eight months). It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

1. Resolution EB136.R8 Global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications

2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)

Category: 2. Noncommunicable diseases

Programme area(s): Mental health and substance abuse

Outcome: 2.2. Increased access to services for mental health and substance use disorders

Output: 2.2.2. Mental health promotion, prevention, treatment and recovery services improved through advocacy, better guidance and tools on integrated mental health services

How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?

The review and evaluation of actions for epilepsy prevention and control, which WHO has been leading, coordinating and supporting, will establish a set of best practices to Member States, and especially to low- and middle-income countries. In addition, the introduction and implementation of national epilepsy programmes and services will provide technical and, wherever possible, financial support to Member States for epilepsy prevention and control. Most importantly, the implementation of actions as proposed in the resolution – strengthening of leadership, governance and implementation of policies and plans for epilepsy prevention and control; integration of epilepsy management in primary health care; increased awareness; investments in research; monitoring of the progress of Member States’ coordinated country-level actions for epilepsy prevention and control and the establishment of international partnerships – will altogether increase access to services for mental health and substance use disorders (Outcome 2.2).

Does the Programme budget already include the outputs and deliverables 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) Five and a half years (covering the period July 2015 – December 2020, in accordance with the duration of the comprehensive mental health action plan 2013–2020).

(ii) Total: US\$ 25 million (staff: US\$ 11 million; activities: US\$ 14 million).

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 700 000 (staff: US\$ 200 000; activities: US\$ 500 000).

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 2014–2015? (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.

No additional staff will be required for the biennium 2014–2015. WHO staff will lead the conceptualization and introduction and formulate the timeline of the epilepsy programme for which implementation will begin in 2016. From January 2016, the following staff additions will be required:

At headquarters: 1.5 staff members (one international expert in public health and neurology (100% full-time equivalent) at grade P.4, and one secretary (50% full-time equivalent) at grade G.5).

In each of the six regions: 0.5 staff members (six international experts in public health and neurology with knowledge of the needs in their respective regions (50% full-time equivalent; grade P.4)).

4. Funding

Is the estimated cost for the biennium 2014–2015 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\$ 500 000 needs to be mobilized to cover the implementation of activities on the prevention and control of epilepsy from July to December 2015 through the Organization's coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015. WHO collaborating centres and a network of experts and civil society stakeholders will be utilized for taking forward the activities. For the second half of 2015, implementation will be with existing staff, and additional qualified staff will be recruited from January 2016.

Resolution EB136.R11	Confirmation of amendments to the Staff Rules: remuneration of staff in the professional and higher categories
Resolution EB136.R13	Confirmation of amendments to the Staff Rules
Resolution EB136.R14	Confirmation of amendments to the Staff Rules
Resolution EB136.R15	Amendments to the Staff Regulations
<p>2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)</p> <p>Category: 6. Corporate services/enabling functions</p> <p>Programme area(s): Management and administration</p> <p>Outcome: 6.4 Output: 6.4.2</p> <p>How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?</p> <p>The amendments outlined in document EB136/47 contribute to the above programme area by simplifying and clarifying several Staff Rules; by providing the Organization with greater flexibility when imposing disciplinary measures; and by putting in place the statutory basis for the Organization's mobility policy.</p> <p>Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)</p> <p>Yes.</p>	
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost</p> <p>Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</p> <p>(i) The resolution is not time-bound.</p> <p>(ii) The total cost to establish and implement the Organization's mobility policy would be approximately US\$ 9.2–10.2 million during the biennium 2016–2017 when implementation starts. Of this amount, US\$ 8–9 million would be costs related to the increased movement of staff members. Approximately US\$ 1.2 million would be staff costs to employ people to help to manage the implementation of the policy.</p> <p>(b) Cost for the biennium 2014–2015</p> <p>Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).</p> <p>Total: US\$ nil (staff: US\$ nil; activities: US\$ nil).</p> <p>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.</p> <p>Not applicable.</p> <p>Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)</p> <p>Not applicable.</p> <p>If "no", indicate how much is not included.</p> <p>(c) Staffing implications</p> <p>Could the resolution be implemented by existing staff? (Yes/no)</p> <p>Yes, for the biennium 2014–2015. However, two additional staff members at grade P.3 and one at grade G.5 will be needed in the Department of Human Resources Management at headquarters during the initial phase of implementation during the biennium 2016–2017. Additional staffing the Department of Human Resources Management, the Global Service Centre and human resources departments in the regional offices may be required from 2018 onwards. A more precise cost estimate will be prepared during 2015 when the implementation plan is finalized.</p> <p>If "no", indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.</p>	

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

Not applicable.

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

Not applicable.

1. Decision EB136(2) Principles for global consensus on the donation and management of blood, blood components and medical products of human origin

2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)

Category: 4. Health systems

Programme area(s): Integrated people-centred health services

Outcome: 4.2. Policies, financing and human resources are in place to increase access to integrated people-centred health services

Output: 4.2.3. Guidelines, tools and technical support to countries for improved patient safety and quality of services, and for patient empowerment

How would this decision contribute to the achievement of the outcome(s) of the above programme area(s)?

The decision would support and facilitate the development of global consensus and harmonized procedures for the implementation of the WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation endorsed by the Health Assembly in 2010, regarding the donation and use of medical products of human origin. Good governance mechanisms, common tools to ensure quality, safety and traceability, and equitable access to and availability of medical products of human origin are needed, where appropriate, to protect donors and recipients.

Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no)

Yes.

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

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

(i) Four years (covering the period 2015–2018).

(ii) Total: US\$ 5.6 million (staff: US\$ 4.6 million; activities: US\$ 1.0 million).

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 1.40 million (staff: US\$ 1.15 million; activities: US\$ 250 000).

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 2014–2015? (Yes/no)

Yes.

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

<p>(c) Staffing implications</p> <p>Could the decision be implemented by existing staff? (Yes/no)</p> <p>Yes.</p> <p>If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.</p>
<p>4. Funding</p> <p>Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)</p> <p>No.</p> <p>If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).</p> <p>The funding gap is US\$ 250 000 (activities). It is expected to be funded by WHO collaborating centres and scientific societies in official relations with WHO.</p>

<p>1. Decision EB136(3) Framework of engagement with non-State actors</p>			
<p>2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)</p> <p>Category: 6. Corporate services/enabling functions</p> <table border="0"> <tr> <td style="vertical-align: top;"> <p>Programme area(s): Leadership and governance</p> </td> <td style="vertical-align: top;"> <p>Outcome: 6.1. Greater coherence in global health, with WHO taking the lead in enabling the many different actors to play an active and effective role in contributing to the health of all people</p> <p>Output: 6.1.2. Effective engagement with other stakeholders in building a common health agenda that responds to Member States’ priorities</p> </td> </tr> </table> <p>How would this decision contribute to the achievement of the outcome(s) of the above programme area(s)?</p> <p>The decision will enable the Sixty-eighth World Health Assembly to approve the framework of engagement with non-State actors</p> <p>Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no)</p> <p>Yes.</p>		<p>Programme area(s): Leadership and governance</p>	<p>Outcome: 6.1. Greater coherence in global health, with WHO taking the lead in enabling the many different actors to play an active and effective role in contributing to the health of all people</p> <p>Output: 6.1.2. Effective engagement with other stakeholders in building a common health agenda that responds to Member States’ priorities</p>
<p>Programme area(s): Leadership and governance</p>	<p>Outcome: 6.1. Greater coherence in global health, with WHO taking the lead in enabling the many different actors to play an active and effective role in contributing to the health of all people</p> <p>Output: 6.1.2. Effective engagement with other stakeholders in building a common health agenda that responds to Member States’ priorities</p>		
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost</p> <p>Indicate (i) the lifespan of the decision 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) Four months (covering the period February–May 2015).</p> <p>(ii) Total: US\$ 350 000 for the three-day open-ended intergovernmental meeting (staff: US\$ nil; activities: US\$ 350 000).</p> <p>(b) Cost for the biennium 2014–2015</p> <p>Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).</p> <p>Total: US\$ 350 000 (staff: US\$ nil; activities: US\$ 350 000).</p>			

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 2014–2015? (Yes/no)

Yes.

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

(c) Staffing implications

Could the decision 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 2014–2015 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).

Not applicable.

1. Decision EB136(4)

Outcome of the Second International Conference on Nutrition

**2. Linkage to the Programme budget 2014–2015 (see document A66/7
http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)**

Category: 2. Noncommunicable diseases

Programme area: Nutrition

Outcome: 2.5. Reduced nutritional risk factors

Outputs: 2.5.1 Countries enabled to develop, implement and monitor action plans based on the maternal, infant and young child nutrition comprehensive implementation plan

2.5.2 Norms and standards on maternal, infant and young child nutrition, population dietary goals, and breastfeeding updated, and policy options for effective nutrition actions for stunting, wasting and anaemia developed

How would this decision contribute to the achievement of the outcome(s) of the above programme area(s)?

The decision would raise the profile of the programme area in Member States’ policy-making and would highlight priorities for action for the Secretariat and partners.

Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no)

Yes. The Proposed programme budget 2016–2017 also includes the outputs and deliverables requested.

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

(a) Total cost

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

(i) Ten years (covering the period 2015–2024).

(ii) Total: US\$ 250 million (staff: US\$ 113.62 million; activities: US\$ 136.38 million).

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 31 million (staff: US\$ 14.09 million; activities: US\$ 16.91 million).

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

Currently, 44% of costs would be incurred at headquarters, 25% would be incurred in the African Region, and between 4% and 6% in each of the other regions.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)
Yes.

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

(c) Staffing implications

Could the decision 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 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No.

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

The funding gap is estimated at US\$ 13.83 million. It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

1. Decision EB136(5) Strategic budget space allocation

2. Linkage to the Programme budget 2014–2015 (see document A66/7

http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)

Category: 6. Corporate services/enabling functions

Programme area(s): Strategic planning, resource coordination and reporting

Outcome: 6.3. Financing and resource allocation aligned with priorities and health needs of the Member States in a results-based management framework

Output: 6.3.1. Results-based management framework in place including an accountability system for WHO's corporate performance assessment

How would this decision contribute to the achievement of the outcome(s) of the above programme area(s)?

The decision would allow the Working Group on Strategic Budget Space Allocation to continue its work to further develop operational segment 1 of the proposed methodology (Technical cooperation at country level), taking into consideration the issues raised during the 136th session of the Executive Board with regards to the choice of appropriate indicators and availability of data. The Working Group will then report to the Executive Board at its 137th session in May 2015.

Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no)

Yes.

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

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

- (i) Four months (covering the period February–May 2015).
- (ii) Total: US\$ 50 000 (staff: US\$ nil; activities: US\$ 50 000).

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 50 000 (staff: US\$ nil; activities: US\$50 000).

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 2014–2015? (Yes/no)

Yes.

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

(c) Staffing implications

Could the decision 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 2014–2015 indicated in 3(b) fully funded? (Yes/no)

No.

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

The funding gap is US\$ 50 000. It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

1. Decision EB136(16) Overview of reform implementation			
2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf) Category: 6. Corporate services/enabling functions <table border="0"> <tr> <td>Programme area(s): Leadership and governance</td> <td>Outcome: 6.1. Greater coherence in global health, with WHO taking the lead in enabling the many different actors to play an active and effective role in contributing to the health of all people Output: 6.1.4. Integration of WHO reform into the work of the Organization</td> </tr> </table> <p>How would this decision contribute to the achievement of the outcome(s) of the above programme area(s)? The decision will accelerate progress in the area of governance reform.</p> <p>Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no) Yes.</p>		Programme area(s): Leadership and governance	Outcome: 6.1. Greater coherence in global health, with WHO taking the lead in enabling the many different actors to play an active and effective role in contributing to the health of all people Output: 6.1.4. Integration of WHO reform into the work of the Organization
Programme area(s): Leadership and governance	Outcome: 6.1. Greater coherence in global health, with WHO taking the lead in enabling the many different actors to play an active and effective role in contributing to the health of all people Output: 6.1.4. Integration of WHO reform into the work of the Organization		
3. Estimated cost and staffing implications in relation to the Programme budget			
<p>(a) Total cost Indicate (i) the lifespan of the decision 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) Until May 2016. (ii) Total: US\$ 350 000 for each meeting of the proposed open-ended working group, assuming each meeting will last three days (staff: US\$ nil; activities: US\$ 350 000).</p> <p>(b) Cost for the biennium 2014–2015 Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000). Total: US\$ 350 000 (staff: US\$ nil; activities: US\$ 350 000). The above cost is estimated for one meeting of three days. Any additional meeting day or additional meeting would need to be costed separately. 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 2014–2015? (Yes/no) Yes. If “no”, indicate how much is not included.</p> <p>(c) Staffing implications Could the decision 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 2014–2015 indicated in 3(b) fully funded? (Yes/no) No. If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds). The funding gap is US\$ 350 000. It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.			

1. Decision EB136(17) Global strategy and plan of action on public health, innovation and intellectual property

2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)

Category: 4. Health systems

Programme area(s): Access to medicines and health technologies and strengthening regulatory capacity

Outcome: 4.3. Improved access to and rational use of safe, efficacious and quality medicines and health technologies

Output: 4.3.2. Implementation of the global strategy and plan of action on public health, innovation and intellectual property

How would this decision contribute to the achievement of the outcome(s) of the above programme area(s)?

The global strategy and plan of action on public health, innovation and intellectual property aims to increase research and development needed for products for diseases that disproportionately affect developing countries, where access to needed medical technologies is hindered by market failures. By extending the time frame of the global strategy and plan of action, WHO will be able to keep its momentum and continue to advocate the implementation of policies and activities that increase availability of the most needed products. The results of the evaluation exercise will help the Health Assembly to determine new policies to improve the current strategy and ensure the effectiveness of WHO's actions.

Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no)

Yes.

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

(a) Total cost

Indicate (i) the lifespan of the decision 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 global strategy and plan of action will be extended by seven years, covering the period from 2015 to 2022; the evaluation of the global strategy and plan of action will be for two years, covering the period from 2015 to 2017.

(ii) Extension of the global strategy and plan of action: US\$ 100 million (staff: US\$ 60 million; activities: US\$ 40 million).

Evaluation of the global strategy and plan of action: US\$ 670 000 (staff: US\$ 70 000; activities: US\$ 600 000).

Total: US\$ 100.67 million.

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Extension of the global strategy and plan of action: US\$ 7.0 million (staff: US\$ 4.2 million; activities: US\$ 2.8 million).

Evaluation of the global strategy and plan of action: US\$ 400 000 (staff: US\$ 30 000; activities: US\$ 370 000).

Total: US\$ 7.4 million.

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

The majority of the activities will take place at headquarters and in the regional offices.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

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

(c) Staffing implications**Could the decision be implemented by existing staff? (Yes/no)**

No.

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

For the implementation of the strategy from 2015 to 2022, nine additional full-time equivalent staff members in the professional and higher categories and three full-time equivalent staff members in the general service category will be required at headquarters, and two full-time equivalent staff members in the professional and higher categories and one full-time equivalent staff member in the general service category will be required in each regional office.

4. Funding**Is the estimated cost for the biennium 2014–2015 indicated in 3(b) fully funded? (Yes/no)**

No.

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

The funding gap is US\$ 2.5 million. It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.