



WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD

119TH SESSION

GENEVA, 6–8 NOVEMBER 2006

RESOLUTIONS

GENEVA
2007

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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

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

PREFACE

The 119th session of the Executive Board was held at WHO headquarters, Geneva, from 6 to 8 November 2006. The proceedings are published in two volumes. The present volume contains the resolutions. The summary records of the Board's discussions and list of participants and officers, are issued in document EB119/2006-EB120/2007/REC/2.

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 2. Director-General
 - 2.1 Nomination for the post
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¹ As adopted by the Board at its first meeting (6 November 2006).

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RESOLUTIONS

EB119.R1 Nomination for the post of Director-General

The Executive Board,

1. NOMINATES, pursuant to Article 31 of the Constitution, Dr Margaret Chan for the post of Director-General of the World Health Organization;
2. SUBMITS this nomination to the First special session of the World Health Assembly.

(Fifth meeting, 8 November 2006)

EB119.R2 Draft contract of the Director-General

The Executive Board,

In accordance with the requirements of Rule 109 of the Rules of Procedure of the World Health Assembly,

1. SUBMITS to the First special session of the World Health Assembly the draft contract annexed hereto, establishing the terms and conditions of appointment of the Director-General;
2. RECOMMENDS to the First special session of the World Health Assembly the adoption of the following resolution:

The First special session of the World Health Assembly,

I

Pursuant to Article 31 of the Constitution and Rule 109 of the Rules of Procedure of the World Health Assembly,

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

SUSPENDS, in accordance with Rule 122 of its Rules of Procedure, Rule 108 of its Rules of Procedure with regard to the duration of the term of office of the Director-General, for the purpose of determining the duration of the term of office of Dr Margaret Chan;

DECIDES that the term of office of Dr Margaret Chan shall begin on 4 January 2007 and shall end on 30 June 2012;

II

Pursuant to Rule 112 of the Rules of Procedure of the World Health Assembly,

AUTHORIZES the President of the First special session of the World Health Assembly to sign this contract in the name of the Organization.

ANNEX

DRAFT CONTRACT OF THE DIRECTOR-GENERAL

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

WHEREAS

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

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

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

I. (1) The Director-General shall serve from the _____ until the _____ on which date the appointment and this Contract shall terminate.

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

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

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

(5) The Director-General may at any time give six months' notice of resignation in writing to the Board, which is authorized to accept such resignation on behalf of the Health Assembly; in which case, upon the expiration of the said period of notice, the Director-General shall cease to hold the appointment and this Contract shall terminate.

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

II. (1) As from the _____ the Director-General shall receive from the Organization an annual salary of two hundred and seventeen thousand, nine hundred and forty-five United States dollars before staff assessment, resulting in a net salary (to be paid monthly) of one hundred and fifty-four thousand, six hundred and sixty-four United States dollars per

annum at the dependency rate (one hundred and thirty-seven thousand, five hundred and forty-three United States dollars at the single rate) or its equivalent in such other currency as may be mutually agreed between the parties to this Contract.

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

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

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

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

.....

Director-General

.....

President of the
World Health Assembly

(Fifth meeting, 8 November 2006)

EB119.R3 Commemoration of the contribution of the late Dr Jong-wook Lee to the work of WHO

The Executive Board,

Desiring to acknowledge the service of Dr Jong-wook Lee to the World Health Organization,

RECOMMENDS to the First special session of the World Health Assembly the adoption of the following resolution:

The First special session of the World Health Assembly,

Remembering the passing of Dr Jong-wook Lee, Director-General of the World Health Organization;

Paying tribute to his personal sacrifice, dedication and professionalism and the passion with which he met every challenge;

Appreciating his efforts to combat global disease, especially his goals to secure access to antiretroviral treatment for three million people living with HIV/AIDS by 2005 and to eradicate poliomyelitis;

Acclaiming his commitment to WHO's mission to help all peoples to attain the highest possible level of health;

Recalling that the Strategic Health Information Centre at headquarters has been dedicated to, and named after, Dr Lee in recognition of his work for global disease surveillance,

COMMEMORATES the invaluable contribution of Dr Jong-wook Lee to the work of WHO.

(Fifth meeting, 8 November 2006)

EB119.R4 Expression of appreciation to the Acting Director-General

The Executive Board,

On the occasion of the nomination of a person for the post of Director-General;

Commending the remarkable efforts made by the Acting Director-General, Dr Anders Nordström, to ensure continuation of the work and activities of WHO after the untimely death of Dr Jong-wook Lee earlier in the year, in particular in facilitating implementation of resolution EB118.R2 on acceleration of the procedure to elect the next Director-General of the World Health Organization,

EXPRESSES its appreciation to Dr Anders Nordström for his contribution and commitment to the Organization in implementing the global health agenda.

(Fifth meeting, 8 November 2006)



WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD

120TH SESSION

GENEVA, 22–29 JANUARY 2007

**RESOLUTIONS AND DECISIONS
ANNEXES**

**GENEVA
2007**

PREFACE

The 120th session of the Executive Board was held at WHO headquarters, Geneva, from 22 to 29 January 2007. The proceedings are published 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 EB119/2006–EB120/2007/REC/2.

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¹ As adopted by the board at its first meeting (22 January 2007).

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¹ See page 23.

² See Annex 6.

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¹ See Annex 6.

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¹ See Annex 2.

² See Annex 6.

³ See Annex 5.

EB120/27	Health systems. Emergency-care systems
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¹ See Annex 6.

² See Annex 1.

³ See Annex 3.

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¹ See Annex 6.

² See Annex 4.

Diverse

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RESOLUTIONS

EB120.R1 Poliomyelitis: mechanism for management of potential risks to eradication

The Executive Board,

Having considered the report on eradication of poliomyelitis,¹

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:²

The Sixtieth World Health Assembly,

Having considered the report on eradication of poliomyelitis;

Recalling resolution WHA59.1, urging Member States in which poliomyelitis is endemic to act on their commitment to interrupting transmission of wild poliovirus;

Recognizing that the occurrence of endemic poliovirus is now restricted to geographically limited areas in four countries;

Recognizing the need for international consensus on long-term policies to minimize and manage the risks of re-emergence of poliomyelitis in the post-eradication era;

Recognizing that travellers from areas where poliovirus is still circulating may pose a risk of international spread of the virus;

Noting that planning for such international consensus must commence in the near future,

1. URGES all Member States where poliomyelitis is still prevalent, especially the four countries in which poliomyelitis is endemic:

(1) to establish mechanisms to enhance political commitment to, and engagement in, poliomyelitis eradication activities at all levels, and to engage local leadership and members of the remaining poliomyelitis-affected populations in order to ensure full acceptance of, and participation in, poliomyelitis immunization campaigns;

(2) to intensify poliomyelitis eradication activities in order rapidly to interrupt all remaining transmission of wild poliovirus;

¹ Document EB120/4 Rev.1.

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

2. URGES all Member States:

- (1) to protect against importations and international spread of wild polioviruses by reviewing and, if appropriate, updating national policy to recommend full immunization against poliomyelitis for travellers to areas in which poliovirus is circulating;
- (2) to revise national policy and legislation on immunization of travellers from countries in which poliovirus is circulating in accordance with temporary or standing recommendations that may be established under the International Health Regulations (2005) once they enter into force;
- (3) to reduce the potential consequences of importation of wild poliovirus by achieving and maintaining routine immunization coverage against poliomyelitis greater than 90% and, where appropriate, conducting supplementary poliomyelitis immunization activities;
- (4) to strengthen active surveillance for acute flaccid paralysis in order rapidly to detect any circulating wild poliovirus and prepare for certification of poliomyelitis eradication;
- (5) to prepare for the long-term biocontainment of polioviruses by implementing the measures set out under phases 1 and 2 in the current edition of the WHO global action plan for laboratory containment of wild polioviruses;¹

3. REQUESTS the Director-General:

- (1) to continue to provide technical support to the remaining Member States where poliomyelitis is still prevalent in their efforts to interrupt the final chains of transmission of wild poliovirus, and to Member States at high risk of an importation of poliovirus;
- (2) to assist in mobilizing financial resources to eradicate poliomyelitis from the remaining areas where poliovirus is circulating, to provide support to countries currently free of poliomyelitis that are at high risk of an importation of poliovirus, and to minimize the risks of re-emergence of poliomyelitis in the post-eradication era;
- (3) to continue to work with other organizations of the United Nations system on security issues, through mechanisms such as “days of tranquillity”, in areas where better access is required to reach all children;
- (4) to initiate the process for a potential standing recommendation, under the International Health Regulations (2005), on the immunization against poliomyelitis of travellers from areas where poliovirus is circulating;
- (5) to submit proposals to the Sixty-first World Health Assembly with a view to minimizing the long-term risks of reintroduction of poliovirus or re-emergence of poliomyelitis in the post-eradication era, by establishing international consensus on the long-term use of poliomyelitis vaccines and biocontainment of infectious and potentially infectious poliovirus materials.

(Fourth meeting, 23 January 2007)

¹ Document WHO/V&B/03.11 (second edition).

EB120.R2 Appointment of the Regional Director for the Eastern Mediterranean

The Executive Board,

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

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

1. REAPPOINTS Dr Hussein A. Gezairy as Regional Director for the Eastern Mediterranean Region as from 1 October 2007;
2. AUTHORIZES the Director-General to issue to Dr Hussein A. Gezairy a contract for a period of five years from 1 October 2007, subject to the provisions of the Staff Regulations and Staff Rules.

(Third meeting, 23 January 2007)

EB120.R3 Tuberculosis control: progress and long-term planning

The Executive Board,

Having considered the report on tuberculosis control: progress and long-term planning,²

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:³

The Sixtieth World Health Assembly,

Having considered the report on tuberculosis control: progress and long-term planning;

Noting the progress made since 1991 towards achieving the international targets for 2005, and more recently following the establishment, in response to resolution WHA51.13, of the Stop TB Partnership;

Aware of the need to build on this progress and overcome constraints in order to reach the international targets for tuberculosis control for 2015 set by the Stop TB Partnership – in line with the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration to “have halted by 2015 and begun to reverse the incidence of major diseases” – of halving tuberculosis prevalence and death rates by 2015 compared with 1990 levels;

Noting the development of the Stop TB strategy as a comprehensive approach to tuberculosis prevention and control that incorporates the internationally agreed tuberculosis control strategy (DOTS strategy) and represents a significant expansion in the scale and scope of tuberculosis-control activities;

¹ Resolution EM/RC53/R1.

² Document EB120/8.

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

Welcoming the Partnership's Global Plan to Stop TB 2006–2015, which sets out the activities oriented towards implementing the Stop TB strategy and achieving the international targets for tuberculosis control for 2015;

Aware of the need to increase the scope, scale and speed of research needed to achieve the international targets for tuberculosis control for 2015 and the goal of eliminating tuberculosis as a global public-health problem by 2050;

Concerned that delays in implementing the Global Plan will result in increasing numbers of tuberculosis cases and deaths, including those due to multidrug-resistant (and extensively drug-resistant) tuberculosis and to the impact of HIV, and therefore in delays in achieving by 2015 the international targets for tuberculosis control and the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;

Recalling that resolution WHA58.14 encouraged Member States to fulfil their commitments to ensure the availability of sufficient domestic resources and of sufficient external resources to achieve the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration,

1. URGES all Member States:

(1) to develop and implement long-term plans for tuberculosis prevention and control in line with the Global Plan to Stop TB 2006–2015, in the context of overall health development plans, in collaboration with other programmes (including those on HIV/AIDS, child health and strengthening of health systems), and through national Stop TB partnerships where appropriate, with the aim of:

(a) accelerating progress towards the international targets for tuberculosis control for 2015 through full and rapid implementation of the Stop TB strategy;

(b) accelerating improvement of health-information systems in order to serve the assessment of national programme performance;

(c) limiting the emergence and transmission of multidrug-resistant tuberculosis, including extensively drug-resistant tuberculosis, by ensuring high-quality implementation of the DOTS strategy by tuberculosis programmes as the first and foremost step in full implementation of the Stop TB strategy, and by prompt implementation of infection-control precautions;

(d) if affected, immediately addressing extensively drug-resistant tuberculosis as part of the overall Stop TB strategy, as the highest health priority;

(e) enhancing laboratory capacity in order to provide for rapid drug-susceptibility testing of isolates obtained from all persons with culture-positive tuberculosis, and promote access to quality-assured sputum smear microscopy;

(f) increasing access to quality-assured second-line medicines at affordable prices through the Stop TB Partnership's Green Light Committee;

(2) to use all possible financing mechanisms in order to fulfil the commitments made in resolution WHA58.14, including that to ensure sustainable domestic and external

financing, thereby filling the funding gaps identified in the Global Plan to Stop TB 2006–2015;

(3) to declare, where appropriate, tuberculosis as an emergency and to allocate additional resources in order to strengthen activities aimed at stopping the spread of extensively drug-resistant tuberculosis;

2. REQUESTS the Director-General:

(1) to intensify support provided to Member States in expanding implementation of the Stop TB strategy by developing capacity and improving the performance of national tuberculosis-control programmes, particularly the quality of DOTS activities, and by implementing infection-control precautions within the broad context of strengthening health systems in order to achieve the international targets for 2015;

(2) to strengthen urgently WHO's support to countries affected by extensively drug-resistant tuberculosis;

(3) to enhance WHO's leadership within the Stop TB Partnership in its coordination of efforts to implement the Global Plan to Stop TB 2006–2015 and to facilitate long-term commitment to sustainable financing of the Global Plan through improved mechanisms for increased funding;

(4) to strengthen mechanisms to review and monitor estimates of impact of control activities on the tuberculosis burden, including incidence, prevalence and mortality;

(5) to support Member States in developing laboratory capacity to provide for rapid drug-susceptibility testing of isolates obtained from all persons with culture-positive tuberculosis;

(6) to enhance WHO's role in tuberculosis research in order to promote the applied research necessary to reach the international targets for tuberculosis control for 2015 and the basic research necessary to achieve the goal of eliminating tuberculosis by 2050; and to increase global support for those areas of tuberculosis research that are currently underresourced;

(7) to report to the Sixty-third World Health Assembly through the Executive Board on:

(a) progress in implementation of the Global Plan to Stop TB 2006–2015, including mobilization of resources from domestic and external sources for its implementation;

(b) progress made in achieving the international targets for tuberculosis control by 2015, using the “proportion of tuberculosis cases detected and cured under directly observed treatment, short course (DOTS)” (Millennium Development Goal indicator 24) as a measure of the performance of national programmes, and tuberculosis incidence and “prevalence and death rates associated with tuberculosis” (Millennium Development Goal indicator 23) as a measure of the impact of control on the tuberculosis epidemic.

(Eighth meeting, 25 January 2007)

EB120.R4 Health systems: emergency-care systems

The Executive Board,

Having considered the report on health systems: emergency-care systems;¹

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:²

The Sixtieth World Health Assembly,

Having considered the report on health systems: emergency-care systems;

Recalling resolutions WHA56.24 on implementing the recommendations of the *World report on violence and health* and WHA57.10 on road safety and health, which respectively noted that violence was a leading worldwide public health problem and that road-traffic injuries caused extensive and serious public-health problems;

Further recalling that resolution WHA56.24 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 recommended Member States to strengthen emergency and rehabilitation services, and requested the Director-General to provide technical support for strengthening systems of prehospital and trauma care for victims of road-traffic injuries;

Recognizing that each year worldwide more than 100 million people sustain injuries, that 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;

Aware of the need for primary prevention as one of the most important ways to reduce the burden of injuries;

Recognizing that improved organization and planning for provision of trauma and emergency care is an essential part of integrated health-care delivery, plays an important role in preparedness for, and response to, mass-casualty incidents, and can lower mortality, reduce disability and prevent other adverse health outcomes arising from the burden of everyday injuries;

Considering that WHO's published guidance and electronic tools offer a means to improve the organization and planning of trauma and emergency care that is particularly adapted to meeting the needs of low- and middle-income countries;

1. CONSIDERS that additional efforts should be made globally to strengthen provision of trauma and emergency care so as to ensure timely and effective delivery to those who need it in the context of the overall health-care system, and related health and health-promotion initiatives;

¹ Document EB120/27.

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

2. URGES Member States:

- (1) to assess comprehensively the prehospital and emergency-care context including, where necessary, identifying unmet needs;
- (2) to ensure involvement of ministries of health in, and an intersectoral coordination mechanism for, review and strengthening of the provision of trauma and emergency care;
- (3) to consider establishing formal prehospital trauma and emergency-care systems in locations where they would be cost-effective, including those where the frequency of injury is high, and to draw on informal systems and community resources in order to establish prehospital-care capacity in areas where formal, prehospital, emergency medical-care systems are impractical;
- (4) in settings with a formal, emergency medical-care system, and where appropriate and feasible, to ensure that a monitoring mechanism exists to promote and assure minimum standards for training, equipment, infrastructure and communication;
- (5) in locations with a formal, emergency medical-care system, or where one is being developed, to establish, and make widely known, a universal-access telephone number;
- (6) to identify a core set of trauma and emergency-care services, and to develop methods for assuring and documenting that such services are provided appropriately to all who need them;
- (7) to consider creating incentives for training and to improve working conditions for health-care providers concerned;
- (8) to ensure that appropriate core competencies are part of relevant health curricula and to promote continuing education for providers of trauma and emergency care;
- (9) to ensure that data sources are sufficient to monitor objectively the outcome of efforts to strengthen trauma and emergency-care systems;
- (10) to review and update relevant legislation, including where necessary financial mechanisms and management methods, so as to ensure that a core set of trauma and emergency-care services are accessible to all people who need them;

3. REQUESTS the Director-General:

- (1) to devise standardized tools and techniques for assessing need for prehospital and facility-based capacity in trauma and emergency care;
- (2) to develop techniques for reviewing legislation related to provision of emergency care, and to compile examples of such legislation;
- (3) to determine standards, mechanisms, and techniques for inspection of facilities, and to provide support to Member States for design of quality-improvement programmes and other methods needed for competent and timely provision of essential trauma and emergency care;
- (4) to provide guidance for the creation and strengthening of mass-casualty management systems;

- (5) to provide support to Member States, upon request, for needs assessments, facility inspection, quality-improvement programmes, review of legislation, and other aspects of strengthening provision of trauma and emergency care;
- (6) to encourage research and collaborate with Member States in establishing science-based policies and programmes for implementation of methods to strengthen trauma and emergency care;
- (7) to collaborate with Member States, nongovernmental organizations and other stakeholders in order to help ensure that the necessary capacity is in place effectively to plan, organize, administer, finance and monitor provision of trauma and emergency care;
- (8) to raise awareness that low-cost ways exist to reduce mortality through improved organization and planning of provision of trauma and emergency care, and to organize regular expert meetings to further technical exchange and build capacity in this area;
- (9) to report on progress made in implementing this resolution to the Health Assembly, through the Executive Board.

(Ninth meeting, 26 January 2007)

EB120.R5 Oral health: action plan for promotion and integrated disease prevention

The Executive Board,

Having considered the report on oral health: action plan for promotion and integrated disease prevention,¹ and the report on prevention and control of noncommunicable diseases: implementation of the global strategy,²

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:³

The Sixtieth World Health Assembly,

Recalling resolutions WHA22.30, WHA28.64 and WHA31.50 on fluoridation and dental health, WHA36.14 on oral health in the strategy for health for all, WHA42.39 on oral health; WHA56.1 and WHA59.17 on the WHO Framework Convention on Tobacco Control; WHA58.22 on cancer prevention and control; WHA57.14 on scaling up treatment and care within a coordinated and comprehensive response to HIV/AIDS; WHA57.16 on health promotion and healthy lifestyles; WHA57.17 on the Global Strategy on Diet, Physical Activity and Health; WHA58.16 on strengthening active and healthy ageing; WHA51.18 and WHA53.17 on prevention and control of noncommunicable diseases, and WHA58.26 on public-health problems caused by harmful use of alcohol;

¹ Document EB120/10.

² Document EB120/22.

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

Acknowledging the intrinsic link between oral health, general health and quality of life;

Emphasizing the need to incorporate programmes for promotion of oral health and prevention of oral diseases into programmes for the integrated prevention and treatment of chronic diseases;

Aware that the importance of the prevention and control of noncommunicable diseases has been highlighted in the Eleventh General Programme of Work 2006–2015;

Appreciating the role that WHO collaborating centres, partners and nongovernmental organizations play in improving oral health globally,

1. URGES Member States:

(1) to adopt measures to ensure that oral health is incorporated as appropriate into policies for the integrated prevention and treatment of chronic noncommunicable diseases;

(2) to take measures to ensure that evidence-based approaches are used to incorporate oral health into national policies as appropriate for integrated prevention and control of noncommunicable diseases;

(3) to consider mechanisms to provide coverage of the population with essential oral-health care, to incorporate oral health in the framework of enhanced primary health care for chronic noncommunicable diseases, and to promote the availability of oral-health services that should be directed towards disease prevention and health promotion for poor and disadvantaged populations, in collaboration with integrated programmes for the prevention of chronic noncommunicable diseases;

(4) for those countries without access to optimal levels of fluoride, and which have not yet established systematic fluoridation programmes, to consider the development and implementation of fluoridation programmes, giving priority to equitable strategies such as the automatic administration of fluoride, for example, in drinking-water, salt or milk, and to the provision of affordable fluoride toothpaste;

(5) to take steps to ensure that prevention of oral cancer is an integral part of national cancer-control programmes, and to involve oral-health professionals or primary health care personnel with relevant training in oral health in detection, early diagnosis and treatment;

(6) to take steps to ensure the prevention of oral disease associated with HIV/AIDS, and the promotion of oral health and quality of life for people living with HIV, involving oral-health professionals or staff who are specially trained in primary health care, and applying primary oral-health care where possible;

(7) to develop and implement the promotion of oral health and prevention of oral disease for preschool and school children as part of activities in health-promoting schools;

(8) to scale up capacity to produce oral-health personnel, including dental hygienists, nurses and auxiliaries, providing for equitable distribution of these auxiliaries to the primary-care level, and ensuring proper service back-up by dentists through appropriate referral systems;

(9) to develop and implement, in countries affected by noma, national programmes to control the disease within national programmes for the integrated management of childhood illness and for the reduction of malnutrition and poverty, in line with internationally agreed health-related development goals, including those contained in the Millennium Declaration;

(10) to incorporate an oral-health information system into health surveillance plans so that oral-health objectives are in keeping with international standards, and to evaluate progress in promoting oral health;

(11) to strengthen oral-health research and use evidence-based oral-health promotion and disease prevention in order to consolidate and adapt oral-health programmes, and to encourage the intercountry exchange of reliable knowledge and experience of community oral-health programmes;

(12) to address human resources and workforce planning for oral health as part of every national plan for health;

(13) to consider increasing the budgetary provisions dedicated to the prevention and control of oral and craniofacial diseases and conditions;

2. REQUESTS the Director-General:

(1) to raise awareness of the global challenges to improving oral health, and the specific needs of low-income countries and of poor and disadvantaged population groups;

(2) to ensure that the Organization, at global and regional levels, provides advice and technical support, on request, to Member States for the development and implementation of oral-health programmes within integrated approaches to monitoring, prevention and management of chronic noncommunicable diseases;

(3) continually to promote international cooperation and interaction with and among all actors concerned with implementation of the oral-health action plan, including WHO collaborating centres for oral health and nongovernmental organizations;

(4) to communicate to UNICEF and other organizations of the United Nations system that undertake health-related activities, the importance of integrating oral health into their programmes;

(5) to strengthen WHO's technical leadership in oral health.

(Ninth meeting, 26 January 2007)

EB120.R6 Integrating gender analysis and actions into the work of WHO: draft strategy

The Executive Board,

Having considered the draft strategy for incorporating a gender perspective into the mainstream of WHO's work,¹

¹ Document EB120/6.

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:¹

The Sixtieth World Health Assembly,

Having considered the draft strategy for incorporating a gender perspective into the mainstream of WHO's policies and programmes;

Recalling the Programme of Action of the International Conference on Population and Development (Cairo, 1994), the Beijing Declaration and Platform for Action (Beijing, 1995), the recommendations of Beijing plus 10 Conference (2005) and their reports, the Economic and Social Council's agreed conclusions 1997/2, the United Nations Millennium Declaration 2000, the 2005 World Summit Outcome² and resolution WHA58.30 on accelerating achievement of the internationally agreed health-related development goals, including those contained in the Millennium Declaration,

1. NOTES WITH APPRECIATION the strategy for incorporating a gender perspective into the mainstream of WHO's work;

2. URGES Member States:

(1) to include gender analysis and planning in joint strategic and operational planning, including country cooperation strategies;

(2) to formulate national strategies for addressing gender issues in health policies, programmes and research, including in the area of reproductive and sexual health;

(3) to lay emphasis on training and sensitization on, and promotion of, gender, women and health;

(4) to ensure that gender-friendly health care is incorporated in all levels of health-care delivery;

(5) to collect and analyse sex-disaggregated data and use the results to inform policies and programmes;

(6) to make progress towards gender equality in the health sector, in order to ensure that the contribution of women, men, girls and boys to health care is considered in health policy and planning;

3. REQUESTS the Director-General:

(1) to assess and address gender differences and inequalities in the planning, implementation, monitoring and evaluation of WHO's work, and to include this requirement in post descriptions and criterion in performance evaluation;

(2) to define indicators and to monitor, and assure accountability for, implementation of the strategy by the Secretariat at headquarters and in regional and country offices;

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

² United Nations General Assembly resolution 60/1.

- (3) to support and sustain incorporation of a gender perspective into the mainstream of WHO's policies and programmes, including through recruiting staff with specific responsibility and experience on gender and women's health;
- (4) to provide support to Member States for formulating and sustaining strategies and action plans for integrating gender equality in all health policies, programmes, and research;
- (5) to give priority to the use of sex-disaggregated data and gender analysis in WHO's publications, and in efforts to strengthen health-information systems, in order to ensure that they reflect awareness of gender equality as a determinant of health;
- (6) to ensure that programmatic and thematic evaluations indicate the extent to which gender issues have been incorporated in the Organization's work;
- (7) to ensure full implementation of the strategy, and to report every two years on progress to the Health Assembly, through the Executive Board.

(Ninth meeting, 26 January 2007)

EB120.R7 Avian and pandemic influenza: developments, response and follow-up, application of the International Health Regulations (2005), and best practice for sharing influenza viruses and sequence data

The Executive Board,

Having considered the reports on avian and pandemic influenza: developments, response and follow-up, application of the International Health Regulations (2005), and best practice for sharing influenza viruses and sequence data,¹

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:²

The Sixtieth World Health Assembly,

Having considered the report on avian and pandemic influenza: developments, response and follow-up;

Recalling resolutions WHA58.5 and WHA59.2, which expressed concern about the potential of the H5N1 strain of *Influenzavirus A* to cause a pandemic and urged Member States to disseminate to WHO collaborating centres information and relevant biological materials, including clinical specimens and viruses;

Recognizing, in particular, the importance of international sharing, with WHO collaborating centres, of clinical specimens and viruses as a contribution to assessment of the pandemic risk, development of pandemic vaccines, updating of diagnostic reagents and test kits, and surveillance for resistance to antiviral medicines,

¹ Documents EB120/15, EB120/16, and EB120/INF.DOC./3, respectively.

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

1. URGES Member States:

- (1) to continue to support the WHO Global Influenza Surveillance Network and its procedures for the routine collection, exchange and characterization of circulating strains of seasonal influenza viruses;
- (2) to establish mechanisms, in accordance with their domestic laws and regulations and international regulations, such as those for biosafety and transportation, that ensure the routine and timely sharing of biological materials related to novel influenza viruses posing a pandemic threat, including H5N1 virus isolates from both humans and animals, and the routine and timely placement of data on the genetic sequences of these viruses in publicly available databases;
- (3) to support implementation of WHO's global pandemic-influenza action plan to increase vaccine supply¹ as a means of increasing availability and access to pandemic influenza vaccines;
- (4) to continue to conduct rapid clinical and epidemiological investigation of human infections, and to share findings in a timely manner with WHO and the international community;

2. REQUESTS the Director-General:

- (1) to continue to coordinate international surveillance of seasonal influenza viruses and viruses with pandemic potential;
- (2) to strengthen the communication mechanism so that national influenza centres receive routine notifications in a timely manner of the summary results of important virological analyses conducted by WHO collaborating centres and H5 reference laboratories;
- (3) to promote the broadest possible access to practical products, including pandemic influenza vaccines, resulting from research on influenza viruses, including the H5N1 strain;
- (4) to take appropriate action if WHO is notified by a Member State that believes that the viruses provided by that Member State were misused by a WHO collaborating centre or an H5 reference laboratory for research or commercial purposes in a manner that violates best practice;²
- (5) to facilitate broader and more equitable regional distribution of production capacity for influenza vaccine and increased production capacity for pandemic vaccines by leading the implementation of WHO's global pandemic-influenza action plan to increase vaccine supply, emphasizing those activities that help to increase access to pandemic vaccines in developing countries and other countries that lack domestic manufacturing capacity;
- (6) as appropriate, to identify, recommend and provide support for the implementation of possible options aimed at promoting the accessibility of a pandemic-influenza vaccine

¹ Document WHO/IVB/06.13 – WHO/CDS/EPR/GIP/2006.1.

² Document EB120/INF.DOC./3.

and antiviral medicines to all, for example by mobilizing adequate funding for research on, and development of, a pandemic-influenza vaccine and antiviral medicines;

(7) to continue to assess the evolving threat of an influenza pandemic and keep the international community informed in a timely manner;

(8) to provide support to developing countries, including those sharing their viruses, for building capacity for surveillance, case detection and reporting by facilitating the participation of scientists from countries sharing viruses in relevant research and analysis conducted by the WHO collaborating centres in the WHO Global Influenza Surveillance Network;

(9) to cooperate with Member States in order to establish feasible and sustainable incentives, including encouragement and public acknowledgement of their contributions, for sharing their viruses and genetic-sequence information;

(10) to mobilize additional support for Member States with vulnerable health systems in order to strengthen these systems and improve their state of preparedness;

(11) to report annually to the Health Assembly, through the Executive Board, on the situation of pandemic influenza and global preparedness.

(Tenth meeting, 26 January 2007)

EB120.R8 Smallpox eradication: destruction of variola virus stocks

The Executive Board,

Having considered the reports on smallpox eradication: destruction of variola virus stocks,¹

SUBMITS to the Sixtieth World Health Assembly for its consideration the following draft resolution:²

The Sixtieth World Health Assembly,

Recalling resolution WHA49.10, which recommended a date for the destruction of the remaining stocks of variola virus, subject to a decision by the Health Assembly, and resolution WHA52.10, which authorized temporary retention of the virus stocks to a later date, subject to annual review by the Health Assembly;

Noting that the Health Assembly decided in resolution WHA55.15 to authorize further, temporary, retention subject to all approved research being outcome-oriented, time-limited and periodically reviewed and to a proposed new date for destruction being set when research accomplishments and outcomes allowed consensus to be reached on the timing of destruction of variola virus stocks;

Noting that authorization was granted to permit essential research for global public-health purposes, including further international research into antiviral agents and improved and safer

¹ Documents EB120/11 and EB120/39.

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

vaccines, and for high priority investigations of the genetic structure of the virus and the pathogenesis of smallpox;

Noting that resolution WHA52.10 requested the Director-General to appoint a group of experts that would establish what research, if any, must be carried out in order to reach global consensus on the timing for destruction of existing variola virus stocks;

Recalling the decisions of previous Health Assemblies that the remaining stocks of the variola virus should be destroyed;

Recognizing that the destruction of all variola virus stocks is an irrevocable event and that the decision of when to do so must be made with great care;

Recalling resolution WHA55.16, which called for a global public-health response to natural occurrence, accidental release or deliberate use of biological and chemical agents or radionuclear material that affect health;

Further recognizing that unknown stocks of live variola virus might exist, and that the deliberate or accidental release of any smallpox viruses would be a catastrophic event for the global community;

Having considered the report on smallpox eradication: destruction of variola virus stocks and the report of the eighth meeting of the WHO Advisory Committee on Variola Virus Research;¹

Noting with satisfaction the considerable progress achieved in the development of antiviral agents, improved and safer vaccines, and sensitive and specific diagnostic tests, and in sequencing of entire genomes of viruses from numerous different strains;

Aware that no antiviral agents for smallpox have been licensed, that live variola virus will be needed to ensure efficacy testing in vitro, and that further refinement of the animal model might be needed to make it more suitable for efficacy testing of these agents;

Further noting that the WHO-led inspections in 2005 of the two authorized repositories reaffirmed that the safety and security of the virus stocks are satisfactory;

Noting that the WHO Advisory Committee on Variola Virus Research at its seventh meeting perceived an urgent need to review all proposals for further research using live variola virus against the considerable progress made to date;²

Further noting that the Secretariat, as requested by the WHO Advisory Committee, has identified a format for research proposals and has established a protocol and time frame for their submission to the Committee for its consideration, and that approved research is reported to WHO according to an established protocol;

1. **STRONGLY REAFFIRMS** the decisions of previous Health Assemblies that the remaining stocks of variola virus should be destroyed;

¹ Documents EB120/11 and EB120/39, respectively.

² See document A59/10.

2. FURTHER REAFFIRMS:

(1) the need to reach consensus on a proposed new date for the destruction of variola virus stocks, when research outcomes crucial to an improved public-health response to an outbreak so permit;

(2) the decision in resolution WHA55.15 (to continue the work of the Advisory Committee on Variola Virus Research with respect to the research involving variola virus stocks and to ensure that the research programme is conducted in an open and transparent manner) that the research programme shall be conducted in an open and transparent manner only with the agreement and under the control of WHO;

3. DECIDES to include a substantive item: “Smallpox eradication: destruction of variola virus stocks” on the provisional agenda of the **[Sixty-third/Sixty-fourth]** World Health Assembly;

4. REQUESTS the Director-General:

(1) to undertake a major review **[in 2009/2010]** of the results of the research undertaken, currently under way, and the plans and requirements for further essential research for global public health purposes, taking into account the recommendations of the WHO Advisory Committee on Variola Virus Research, so that the **[Sixty-third/Sixty-fourth]** World Health Assembly may reach global consensus on the timing of the destruction of existing variola virus stocks;

(2) to continue the work of the WHO Advisory Committee on Variola Virus Research, and to disseminate its recommendations more widely to the scientific community;

(3) to review the membership of the WHO Advisory Committee and the representation of advisers and observers at meetings of this Committee, in order to ensure balanced geographical representation, with the inclusion of experts from developing countries, and substantial representation of public-health experts, and the independence of the members of this Committee from any conflict of interest;

(4) to ensure that approved research proposals, research outcomes and the benefits of this research are made available to all Member States;

(5) to maintain biannual inspections of the two authorized repositories in order to ensure that conditions of storage of the virus and of research conducted in the laboratories meet the highest requirements for biosafety and biosecurity;

(6) to develop continually the operational framework for WHO’s smallpox vaccine reserve;

(7) to continue to report annually on progress in the research programme, biosafety, biosecurity and related issues to the Health Assembly, through the Executive Board, and on implementation of the recommendations of the WHO Advisory Committee on Variola Virus Research accepted by the Director-General;

(8) to ensure that any research undertaken does not involve genetic engineering of the variola virus;

- (9) to ensure that the two authorized repositories of live virus, and any other institution that has fragments of variola virus DNA, distribute such DNA only for purposes of research on diagnostics, treatment and vaccines, in accordance with recommendations of the WHO Advisory Committee on Variola Virus Research;
- (10) to submit an annual detailed report to the Health Assembly, through the Executive Board, on the research that has been completed, the results of such research, research being undertaken, and research being planned at the two authorized repositories;
- (11) to submit to the Sixty-first World Health Assembly a report on the legal status of the variola virus strains held at the two repositories with respect to their ownership;
- (12) to submit a report to the Sixty-first World Health Assembly, through the Executive Board, on measures that promote in Member States the widest and most equitable access possible to the outcomes of the research, including antiviral agents, vaccines and diagnostic tools.

(Eleventh meeting, 27 January 2007)

EB120.R9 Amendments to the Financial Regulations and Financial Rules

The Executive Board,

Having examined the report of the Director-General on the proposed amendments to the Financial Regulations and Financial Rules, and the proposed introduction of the International Public Sector Accounting Standards,¹

1. CONFIRMS, in accordance with Financial Regulation 16.3, the deletion of Financial Rule 104.2 relating to the financial incentive scheme, to be effective as from the date on which the Health Assembly deletes Financial Regulations 6.5 and 8.2.
2. RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:

The Sixtieth World Health Assembly,

Having considered the report on the introduction of the International Public Sector Accounting Standards (IPSAS) and associated amendments to the Financial Regulations proposed by the Director-General and endorsed by the Executive Board at its 120th session;

1. ENDORSES the introduction of IPSAS;
2. NOTES the change to the United Nations System Accounting Standards (UNSAS) that will permit WHO to introduce IPSAS progressively;
3. Further NOTES that the Director-General shall submit to the governing bodies for consideration at future sessions proposals to amend the Financial Regulations and Financial Rules resulting from the adoption of IPSAS;

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

4. ADOPTS amendments to Financial Regulation 4.4 in order to clarify operation of the exchange-rate facility, to be effective as from 1 January 2008, and to Financial Regulation 4.5 in order to permit regular budget resources to be carried forward to pay for commitments made before the end of a financial period and undertaken by the end of the first year of the next financial period;

5. DELETES Financial Regulations 6.5 and 8.2 in order to terminate the financial incentive scheme that has failed to encourage prompt payment of Member States' assessments, to be effective as from 1 January 2008;

(Twelfth meeting, 29 January 2007)

EB120.R10 Confirmation of amendments to the Staff Rules¹

The Executive Board,

CONFIRMS, in accordance with Staff Regulation 12.2, the amendments to the Staff Rules that have been made by the Acting Director-General:² (a) with effect from 1 January 2007 concerning the remuneration of staff in the professional and higher categories; (b) with effect from the school year in progress on 1 January 2007 concerning the education grant; and (c) with effect from 1 July 2007 concerning home leave, special leave, leave without pay, leave for military training or service, sick leave (family-emergency leave), maternity leave, paternity leave, adoption leave, travel of staff members, travel of children under the education grant, resignation, completion of appointments, notice of termination, and effective date of termination.

(Twelfth meeting, 29 January 2007)

EB120.R11 Confirmation of amendments to the Staff Rules

The Executive Board,

Having considered the report on confirmation of amendments to the Staff Rules,¹

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:

The Sixtieth 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 as from 1 January 2007 at US\$ 168 826 per annum before staff assessment, resulting in a modified net salary of US\$ 122 737 (dependency rate) or US\$ 111 142 (single rate);

2. ESTABLISHES the salary of the Deputy Director-General as from 1 January 2006 at US\$ 181 778 per annum before staff assessment, resulting in a net salary of US\$ 131 156 (dependency rate) or US\$ 118 034 (single rate); and, as from 1 January 2007, at US\$ 185 874

¹ See Annex 1.

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

per annum before staff assessment, resulting in a net salary of US\$ 133 818 (dependency rate) or US\$ 120 429 (single rate);

3. ESTABLISHES the salary of the Director-General as from 1 January 2007 at US\$ 228 818 per annum before staff assessment, resulting in a modified net salary of US\$ 161 732 (dependency rate) or US\$ 143 829 (single rate).

(Twelfth meeting, 29 January 2007)

EB120.R12 Rational use of medicines

The Executive Board,

Having considered the report on progress in the rational use of medicines, including better medicines for children,¹

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:²

The Sixtieth World Health Assembly,

Having considered the report on rational use of medicines: progress in implementing the WHO medicines strategy;

Recalling the report on rational use of medicines by prescribers and patients, discussed at the Fifty-eighth World Health Assembly, and followed by adoption of resolution WHA58.27 on antimicrobial resistance;

Recalling resolutions WHA39.27, WHA41.16 and WHA47.13 on the rational use of drugs, WHA41.17, WHA45.30 and WHA47.16 on ethical criteria for medicinal drug promotion, WHA43.20 and WHA45.27 on the WHO Action Programme on Essential Drugs, WHA47.12 on the role of the pharmacist, WHA49.14 and WHA52.19 on the revised drug strategy, WHA51.9 on cross-border advertising, promotion and sale of medical products using the Internet, and WHA54.11 on the WHO medicines strategy;

Recognizing the efforts of WHO in collaboration with governments, universities, the private sector, and nongovernmental organizations, in areas related to health-care delivery systems and health-insurance programmes in order to improve the use of medicines by prescribers, dispensers and patients;

Aware of the core components of WHO's strategy for promoting the rational use of medicines;³

Wishing to promote evidence-based rational use of medicines by providers and consumers and better access to essential medicines;

Aware that irrational use of medicines continues to be an urgent and widespread problem in the public and private health sector in developed and developing countries with serious

¹ Document EB120/7.

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

³ Document WHO/EDM/2004.5.

consequences in terms of poor patient outcome, adverse drug reactions, increasing antimicrobial resistance and wasted resources;

Acknowledging that successful implementation of previous resolutions on antimicrobial resistance cannot be achieved without addressing the global problem of irrational use of medicines;

Recognizing that many countries do not have a stringent drug-regulatory authority nor a full national programme or body to promote rational use of medicines;

Emphasizing that global initiatives to increase access to essential medicines should adhere to the principle of rational use of medicines, and include adherence by patients;

Concerned that insufficient attention and resources are being directed towards tackling the problem of irrational use of medicines by prescribers, dispensers and consumers;

Emphasizing the need for a comprehensive, sustainable, national and sector-wide approach to promote the rational use of medicines;

Recognizing that financing of medicines and methods of arrangements for provider payments can have a major impact on rational use, and that appropriate policies on financing health care are required;

Recognizing that there may be incentives for the irrational use of medicines throughout the health system, for example in some circumstances which give rise to conflict of interest;

Concerned that direct-to-consumer or Internet sales may give rise to irrational use of medicines;

Convinced that it is time for governments, the health professions, civil society, the private sector and the international community to pledge their commitment, including adequate resources, to promoting the rational use of medicines,

1. URGES Member States:¹

(1) to invest sufficiently in human resources and provide adequate financing in order to strengthen institutional capacity in order to ensure more appropriate use of medicines in both the public and private sectors;

(2) to consider establishing and/or strengthening, as appropriate, a national drug regulatory authority and a full national programme and/or multidisciplinary body, involving civil society and professional bodies, to monitor and promote the rational use of medicine;

(3) to consider developing, strengthening and implementing, where appropriate, the application of an essential medicines list into the benefit package of the existing or new insurance funds;

(4) to develop and strengthen existing training programmes on rational use of medicines and ensure that they are taken into account in the curricula for all health professionals and medical students, including their continuing education, where appropriate, and to promote programmes of public education in rational use of medicines;

¹ And regional economic integration organizations, where appropriate.

- (5) to enact new, or enforce existing, legislation to ban inaccurate, misleading or unethical promotion of medicines, to monitor promotion of medicines, and to develop and implement programmes that will provide independent, nonpromotional information about medicines;
- (6) to develop and implement national policies and programmes for improving medicine use, including clinical guidelines and essential medicines lists, as appropriate, with an emphasis on multifaceted interventions targeting both the public and private health sectors, and involving providers and consumers;
- (7) to consider developing, and strengthening where appropriate, the capacity of hospital drug and therapeutic committees to promote the rational use of medicines;
- (8) to expand to national level sustainable interventions successfully implemented at local level;

2. REQUESTS the Director-General:

- (1) to strengthen the leadership and evidence-based advocacy role of WHO in promoting rational use of medicines;
- (2) in collaboration with governments and civil society, to strengthen WHO's technical support to Member States in their efforts to establish or strengthen, where appropriate, multidisciplinary national bodies for monitoring medicine use, and implementing national programmes for the rational use of medicines;
- (3) to strengthen the coordination of international financial and technical support for rational use of medicines;
- (4) to promote research, particularly on development of sustainable interventions for rational medicine use at all levels of the health sector, both public and private;
- (5) to promote discussion among health authorities, professionals and patients on the rational use of medicines;
- (6) to report to the Sixty-second World Health Assembly, and subsequently biennially, on progress achieved, problems encountered and further actions proposed in the implementation of WHO's programmes to promote rational use of medicines.

(Twelfth meeting, 29 January 2007)

EB120.R13 Better medicines for children

The Executive Board,

Having considered the report on progress in the rational use of medicines, including better medicines for children,¹

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:²

¹ Document EB120/37.

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

The Sixtieth World Health Assembly,

Having considered the report on better medicines for children;

Recalling resolutions WHA39.27, WHA41.16 and WHA47.13 on the rational use of drugs, WHA41.17 on ethical criteria for medicinal drug promotion, WHA43.20 and WHA45.27 on the WHO Action Programme on Essential Drugs, WHA47.12 on the role of the pharmacist in support of the WHO revised drug strategy, WHA49.14 and WHA52.19 on the revised drug strategy, WHA54.11 on the WHO medicines strategy, and WHA58.27 on improving the containment of antimicrobial resistance;

Recognizing the efforts of WHO in collaboration with governments, other organizations in the United Nations system, universities, the private sector, nongovernmental organizations and funding agencies in areas related to improving access to better medicines for children;

Aware of the core components of WHO's global framework for expanding access to essential medicines;

Wishing to promote evidence-based selection and use of medicines for children by health providers and carers;

Aware that there are regional initiatives to address inadequate access to essential medicines for children;

Wishing to ensure better access to essential medicines for children as a prerequisite for achieving health outcomes as set out in the internationally agreed health-related development goals, including those contained in the Millennium Declaration;

Aware that the lack of access to essential medicines of assured quality continues to pose significant risks of high morbidity and mortality in children, especially those under five years of age;

Concerned that children can be further disadvantaged by lack of physical and economic access to essential medicines, especially in vulnerable communities;

Recognizing that many countries do not have the requisite capacity to regulate and control medicines for children;

Aware that many manufacturers of essential medicines have neither developed nor produced appropriate dosage forms and strengths of medicines for children;

Concerned that there is insufficient investment in the clinical trials, development and manufacture of medicines for children;

1. URGES Member States:

(1) to take steps to identify appropriate dosage forms and strengths of medicines for children, and to encourage their manufacture and licensing;

(2) to investigate whether currently available medicines could be formulated to make them suitable for use in children;

- (3) to encourage research and development of appropriate medicines for diseases that affect children, and to ensure that high-quality clinical trials for these medicines are conducted in an ethical manner;
- (4) to facilitate timely licensing of appropriate, high-quality and affordable medicines for children and innovative methods for monitoring the safety of such medicines, and to encourage the marketing of adequate paediatric formulations together with newly developed medicines;
- (5) to promote access to essential medicines for children through inclusion, as appropriate, of those medicines in national medicine lists, and procurement and reimbursement schemes, and to devise measures to monitor prices;
- (6) to collaborate in order to facilitate innovative research and development on, formulation of, regulatory approval of, provision of adequate prompt information on, and rational use of, paediatric medicines and medicines authorized for adults but not approved for use in children;
- (7) to use mechanisms including, where appropriate, existing international trade agreements that might impact health, in order to ensure children's access to essential medicines, where applicable;

2. REQUESTS the Director-General:

- (1) to promote the development, harmonization and use of standards for clinical trials of medicines for children; to revise and regularly update the Model List of Essential Medicines in order to include missing essential medicines for children, using evidence-based clinical guidelines; and to promote application of such guidelines by Member States and international financing bodies, with initial focus on treatments for HIV/AIDS, tuberculosis, malaria and chronic diseases;
- (2) to ensure that all relevant WHO programmes, including but not limited to that on essential medicines, contribute to making safe and effective medicines as widely available for children as for adults;
- (3) to promote the development of international norms and standards for quality and safety of formulations for children, and of the regulatory capacity to apply them;
- (4) to make available evidence-based treatment guidelines and independent information on dosage and safety aspects of essential medicines for children, progressively to cover all medicines for children, and to work with Member States in order to implement such guidelines;
- (5) to collaborate with governments, other organizations of the United Nations system, donor agencies and nongovernmental organizations in order to encourage fair trade in safe and effective medicines for children and adequate financing for securing better access to medicines for children;
- (6) to report to the Sixty-second World Health Assembly, and subsequently as appropriate, through the Executive Board, on progress achieved, problems encountered and specific actions needed to further promote better access to medicines for children.

(Twelfth meeting, 29 January 2007)

EB120.R14 Health promotion in a globalized world

The Executive Board,

Having considered the report on health promotion in a globalized world,¹

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:²

The Sixtieth World Health Assembly,

Recalling resolutions WHA42.44 on health promotion, public information and education for health, WHA51.12 on health promotion, WHA57.16 on health promotion and healthy lifestyles, and the outcomes of the six international conferences on health promotion (Ottawa, 1986; Adelaide, Australia, 1988; Sundsvall, Sweden, 1991; Jakarta, 1997; Mexico City, 2000; Bangkok, 2005);

Having considered the report on follow-up to the 6th Global Conference on Health Promotion (Bangkok in 2005), which confirms the need to focus on health promotion actions to address the determinants of health;

Drawing on the Declaration of Alma-Ata, the Ottawa Charter for Health Promotion, and the Bangkok Charter for Health Promotion in a Globalized World which sets out strategic directions for equitable health improvement in the first decades of the twenty-first century;

Considering the actions and recommendations set out in the Bangkok Charter for Health Promotion in a Globalized World to make the promotion of health central to the global development agenda, a core responsibility for all governments and a key focus of communities, civil society, and the private sector;

Noting that health promotion is essential for meeting the targets of the internationally agreed health-related development goals, including those contained in the Millennium Declaration, is intimately related to the work of WHO's Commission on Social Determinants of Health, and makes an important contribution to realizing the objectives of the Eleventh General Programme of Work;

Recognizing that the dramatic changes of the global burden of disease require greater attention, and call for adjustments in society at large and in resource allocation in order to tackle the immediate and underlying determinants of health;

Confirming the importance of addressing also the wider determinants of health, and of implementing recommendations on, and undertaking action for, health for all,

1. URGES all Member States:

(1) to increase, as appropriate, investments in, and to frame sound policies for, health promotion as an essential component of equitable social and economic development;

¹ Document EB120/12.

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

- (2) to establish, as appropriate, effective mechanisms for a multisectoral approach in order to address effectively the social, economic, political and environmental determinants of health throughout the life-course;
- (3) to support and foster the active engagement in health promotion of communities, civil society, the public and private sectors and nongovernmental organizations, including associations of public health, while avoiding any possible conflict of interest;
- (4) to monitor and evaluate systematically health-promotion policies, programmes, infrastructure and investment, on a regular basis, including consideration of the use of health-impact assessments;
- (5) to close the gap between current practices and those functions based on the evidence of effective health promotion by the full use of evidence-based health promotion;

2. REQUESTS the Director-General:

- (1) to strengthen the capacity for health promotion across the Organization in order to provide better support to Member States by advancing knowledge and the active engagement of other appropriate organizations of the United Nations system and international organizations;
- (2) to provide support to Member States in their continuous efforts to strengthen national health systems with a special focus on the primary health sector, in order to enhance the ability to tackle serious threats to health, including those caused by noncommunicable diseases;
- (3) to optimize use of existing forums of Member States for multisectoral stakeholders, interested organizations and other bodies, while avoiding any possible conflict of interest, in order to support the development and implementation of health promotion;
- (4) to encourage the convening of national, subregional, regional and global conferences on health promotion on a regular basis;
- (5) to monitor and evaluate progress, to identify major shortcomings in health promotion globally, and to report on a regular basis;
- (6) to facilitate exchange of information with international nonhealth forums on key aspects of health promotion;
- (7) to report to the Sixty-first World Health Assembly, through the Executive Board, on progress in implementing this resolution.

(Twelfth meeting, 29 January 2007)

EB120.R15 WHO's role and responsibilities in health research

The Executive Board,

Having considered the report on WHO's role and responsibilities in health research,¹

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:²

The Sixtieth World Health Assembly,

Recalling resolution WHA58.34 on the Ministerial Summit on Health Research;

Having considered the report on WHO's role and responsibilities in health research;

Acknowledging the critical role of the entire spectrum of health and medical research in improving human health;

Recognizing that research into poverty and inequity in health is limited, and that the ensuing evidence is important to guide policy in order to minimize gaps;

Reaffirming that research to strengthen health systems is fundamental for achieving internationally agreed health-related development goals, including those contained in the United Nations Millennium Declaration;

Recognizing that a wide gap exists between developed and developing countries in the capacity for health research, that it may hamper efforts to achieve better health results, and that it may contribute to worsening the brain drain;

Noting in particular the work of IARC, the WHO Centre for Health Development, the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, and the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction;

Convinced that research findings and data derived from effective health-information systems should be used to inform decisions about the delivery of interventions to those who need them most;

Mindful that the Organization should lead by example in the use of research findings to inform decisions about health;

Reaffirming the role of WHO's cosponsored research programmes in support of neglected areas of research relevant to poor and disadvantaged populations, particularly poverty-related diseases, tuberculosis, malaria and AIDS, and recognizing the contributions of WHO to strengthening research capacity;

Committed to ensuring ethical standards in the conduct of health research supported by the Organization,

¹ Document EB120/14.

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

1. URGES Member States:

- (1) to consider implementing the recommendation made by the Commission on Health Research for Development in 1990 that “developing countries should invest at least 2% of national health expenditures in research and research capacity strengthening, and at least 5% of project and programme aid for the health sector from development aid agencies should be earmarked for research and research capacity strengthening”;¹
- (2) to consider the development and strengthening of resource-tracking tools in order to monitor expenditure on health research from government and donor sources, and to disseminate relevant research findings to policy-makers, civil-society entities and the general public;
- (3) to integrate research in the mainstream of national programme activities and plans, and to promote wider access to research findings;
- (4) to strengthen the capacity of national and institutional ethics committees that review health-research proposals, as appropriate;
- (5) to draw up or strengthen health-research policies and health-research legislative documents, as appropriate;
- (6) to create a sustained training programme for research managers and to facilitate a cadre of trained professionals to manage health research, where necessary;
- (7) to improve the career management of researchers who do not necessarily come under the authority of the ministry responsible for research, as appropriate;
- (8) to consider strengthening national research capacities in the following complementary areas: generation of new knowledge, human and financial resources, research institutes and use of research findings in policy decisions, and to foster national and international networks for research collaboration;
- (9) to develop and strengthen a participatory mechanism, as appropriate, for all stakeholders in order to prioritize the health-research agenda on the basis of dynamic changes in health systems, disease burden, and emerging health-related issues.

2. CALLS UPON the health-research community, other international organizations, the private sector, civil society and other concerned stakeholders to provide strong, sustained support to research activities across the entire spectrum of health, medical and behavioural research, especially research into communicable diseases and poverty and inequity in health, with the participation of communities and in keeping with national priorities, and to maintain support of activities that promote the use of research findings to inform policy, practice and public opinion;

¹ In *Commission on Health Research for Development. Health research: essential link to equity in development*. New York, Oxford University Press, 1990.

3. REQUESTS the Director-General:

- (1) to promote and advocate research in neglected areas of importance for better health, in particular on diseases that disproportionately affect developing countries and for poor and disadvantaged groups;
- (2) to strengthen the culture of research for evidence-based decision-making in the Organization and to ensure that research informs its technical activities;
- (3) to develop a reporting system on WHO's activities in health research;
- (4) to improve significantly coordination of relevant research activities, including integration of research into disease control and prevention, and designate one focal point within the Organization who has the overview of all WHO's research activities;
- (5) to review the use of research evidence for major policy decisions and recommendations within WHO;
- (6) to establish transparent mechanisms for prioritization of research activities and projects within WHO, including independent peer-review mechanisms, and selection criteria such as relevance and scientific quality;
- (7) to establish standard procedures and mechanisms for the conduct of research and use of findings by the Organization, including registration of research proposals in a publicly accessible database, peer review of proposals, and dissemination of findings;
- (8) to advise Member States, when requested, on ways to organize systems for research for better health;
- (9) to promote better access to relevant research findings, including by supporting the movement towards open access to scientific journals;
- (10) to provide support to Member States in order to develop capacities for health-systems and health-policy research, where necessary;
- (11) to provide technical support to Member States for strengthening the capacity of national and institutional health-research ethics committees, reviewing complex research protocols, and drafting national health policies and health-research legislative documents;
- (12) to identify and implement mechanisms to provide better support to countries and regions in recognizing and maximizing health research as a key factor in the development of health systems, in particular in developing countries;
- (13) to formulate simple priority-setting strategies for health research for use by national governments, where appropriate;
- (14) to institute appropriate systems and mechanisms for greater interaction and convergence among researchers and users of relevant research in order to improve use of research findings and to enhance framing of health policy;
- (15) to provide capacity-building opportunities in health economics, assessment of health technology, economic impact of disease, and costing of various interventions in order for a country to optimize its health-system delivery;

(16) to build up capacity in order to monitor and report to Member States on total expenditure on health research by country and region, by public and donor sources, and by type of expenditure;

(17) to submit to the Sixty-second World Health Assembly a strategy for the management and organization of research activities within WHO.

(Twelfth meeting, 29 January 2007)

EB120.R16 Malaria, including a proposal for establishment of World Malaria Day

The Executive Board,

Having considered the report on malaria, including a proposal for establishment of World Malaria Day;¹

Concerned that few malaria-endemic countries have made substantial progress towards achieving the internationally agreed development goals relating to malaria, including those contained in the Millennium Declaration, and that a number of countries have not yet met the commitment to increase their national budgets that they made when adopting the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases;

Noting that valuable opportunities are being created in the form of new tools and better defined strategies, and that the momentum for expanding malaria-control interventions, and increasing financial resources at country and global levels, is growing,

SUBMITS to the Sixtieth World Health Assembly for its consideration the following draft resolution:²

The Sixtieth World Health Assembly,

Having considered the report on malaria, including a proposal for the establishment of Malaria Day;

Concerned that malaria continues to cause more than one million preventable deaths a year;

Noting that the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank Global Strategy and Booster Program, the Bill & Melinda Gates Foundation, the Malaria Initiative of the President of the United States of America, and other donors have made substantial resources available;

Welcoming the contribution to the mobilization of resources for development of voluntary innovative financing initiatives taken by groups of Member States and, in this regard, noting the activities of the International Drug Purchase Facility (UNITAID);

¹ Document EB120/5.

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

Recalling that combating HIV/AIDS, malaria and other diseases is included in internationally agreed health-related development goals, including those contained in the Millennium Declaration;

Mindful that the global burden of malaria needs to be decreased in order to reach the Millennium Development Goal of reducing the mortality rate among children under five by two thirds by 2015 and to help to achieve the Millennium Development Goals of improving maternal health and eradicating extreme poverty,

1. URGES Member States:

(1) to apply to their specific contexts the policies, strategies and tools recommended by WHO, and to establish evidence-based national policies, operational plans and performance-based monitoring and evaluation in order to expand coverage with major preventive and curative interventions in populations at risk and to assess programme performance and the coverage and impact of interventions in an effective and timely manner, particularly with use of the WHO country-profile database;

(2) to assign national and international resources, both human and financial, for the provision of technical support in order to ensure that the most locally and epidemiologically appropriate strategies are effectively implemented and target populations are reached;

(3) progressively to cease the provision in both the public and private sectors of oral artemisinin monotherapies, i.e. artemisinins used alone without the accompaniment of a partner medicine, and to promote the use of artemisinin-combination therapies, to implement policies that prohibit the production of counterfeit antimalarial medicines, and to assure that financing bodies cease to provide for those monotherapies;

(4) to intensify access to affordable, safe and effective antimalarial combination treatments, to intermittent preventive treatment in pregnancies, with special precautions for HIV-infected pregnant women who are receiving co-trimoxazole chemotherapy, to insecticide-treated mosquito nets, including through the free distribution of such nets where appropriate, and to insecticides for indoor residual spraying for malaria control, taking into account relevant international rules, standards and guidelines;

(5) to provide in their legislation for use to the full of the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights in order to increase access to antimalarial medicines, diagnostics and preventive technologies;

OR

(5) to consider, whenever necessary, adapting national legislation in order to use to the full the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights;

(6) to aim at reducing transmission risk-factors through integrated vector management, promoting improvement of local and environmental conditions and healthy settings, and increasing access to health services, **[antimalarial medicines, diagnostics and preventive technologies]** in order to reduce the disease burden;

(7) to implement integrated approaches to malaria prevention and control through multisectoral collaboration and community responsibility and participation;

2. REQUESTS international organizations:

(1) to provide support for the development of capacities in developing countries in order to expand use of artemisinin-based combination therapies that are appropriate for local drug-resistance conditions, of integrated vector management including long-lasting insecticide-treated nets, of indoor residual spraying with appropriate and safe insecticides as indicated by WHO and in accordance with the Stockholm Convention on Persistent Organic Pollutants, and of monitoring and evaluation systems, including of the country database, as developed by WHO;

(2) to increase funding to the various financing mechanisms for malaria control, so that they can continue providing support to countries, and to channel additional resources for technical support so that they can be absorbed and used effectively in countries;

3. REQUESTS the Director-General:

(1) to take steps to identify knowledge gaps for malaria control; to provide support for the development of new tools and strategies; to estimate more accurately the global burden of disease and determine trends; to develop new tools and methods for assessing impact and cost-effectiveness of interventions; to build up WHO's current research on malaria, including that of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases; and to provide technical support to countries for conducting operational and implementation research into ways to ensure adequate coverage with antimalarial interventions;

(2) to strengthen and rationalize human resources for malaria by decentralizing staff to country level, thus improving the capacity of WHO's country offices to provide support to national health programmes for coordinating partners to prevent and control malaria; and to provide technical guidance for the management of malaria control in refugee camps and in complex emergencies;

(3) to bring together WHO's Global Malaria Programme, the Roll Back Malaria Partnership, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the International Drug Purchase Facility (UNITAID), academics, small and large pharmaceutical and biotechnology companies, interested Member States, medical-research councils, and foundations in a forum in order to improve coordination between different stakeholders in the fight against malaria;

(4) to report to the Health Assembly through the Executive Board on progress made in implementation of this resolution;

4. RESOLVES that:

(1) Malaria Day shall be commemorated annually on 25 April or on such other day or days as individual Member States may decide, in order to provide education and understanding of malaria as a global scourge that is preventable and a disease that is curable;

(2) Malaria Day shall be the culmination of year-long intensified implementation of national malaria-control strategies, including community-based activities for malaria

prevention and treatment in endemic areas, and the occasion to inform the general public of the obstacles encountered and progress achieved in controlling malaria.

(Twelfth meeting, 29 January 2007)

EB120.R17 Prevention and control of noncommunicable diseases: implementation of the global strategy

The Executive Board,

Having considered the report on prevention and control of noncommunicable diseases: implementation of the global strategy,¹

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:²

The Sixtieth World Health Assembly,

Having considered the report on prevention and control of noncommunicable diseases: implementation of the global strategy;

Recalling resolutions WHA53.17 on prevention and control of noncommunicable diseases, WHA56.1 on the WHO Framework Convention on Tobacco Control, WHA57.17 on the Global Strategy on Diet, Physical Activity and Health, WHA57.16 on health promotion and healthy lifestyles, WHA58.22 on cancer prevention and control, and WHA58.26 on public-health problems caused by harmful use of alcohol, and the many related regional committee resolutions, including on mental health;

Deeply concerned that in 2005 noncommunicable diseases caused an estimated 35 million deaths (60% of all deaths globally), that 80% of these deaths occurred in low- and middle-income countries, and that about 16 million deaths occurred among people under 70 years of age;

Noting that the mortality due to noncommunicable diseases is expected to rise by a further 17% by 2015, with serious socioeconomic consequences for Member States, communities and families;

Noting the links between noncommunicable diseases, development, the environment, and human security, and their contribution to health inequalities;

Noting that multisectoral responses continue to be limited by lack of awareness of, and appropriate action to reverse, the pandemic of noncommunicable diseases;

Noting that the importance of prevention and control of noncommunicable diseases has been highlighted in the Eleventh General Programme of Work 2006–2015, which includes the target of reducing death rates from noncommunicable diseases by 2% annually during the next 10 years;

¹ Document EB120/22.

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

Noting the increasing evidence on the cost-effectiveness of several simple interventions for prevention and control of noncommunicable diseases;

Noting the importance of motivating, educating and supporting individuals and families to make healthy choices in their daily lives, and the important role played by governments in providing healthy public policy and environments;

Confirming the importance of tackling the major underlying risk factors for noncommunicable diseases in an integrated, comprehensive, multisectoral and step-by-step manner;

Bearing in mind that the response to the triple burden of infectious diseases, noncommunicable diseases and injuries faced by many countries, and their severe resource constraints, requires a strong primary health-care system within an integrated health system;

Recognizing that the implementation of the WHO Framework Convention on Tobacco Control is an essential measure for the prevention and control of noncommunicable diseases;

Recognizing that greater efforts are required globally to promote physical activity and healthy lifestyles, and to improve the nutritional quality of food and drink products, the way in which they are marketed, and the quality of information and its availability to consumers and their families, in particular children, young people and other population groups in vulnerable circumstances;

Recognizing that more information is required on the socioeconomic and developmental impact of noncommunicable diseases and on the outcome of available interventions;

Aware that Member States spend only a small proportion of their health-care budget on prevention of noncommunicable diseases and on public health, and that even a minor increase in that percentage would yield tremendous health and socioeconomic benefits;

1. URGES Member States:

- (1) to strengthen national and local political will to prevent and control noncommunicable diseases as part of a commitment to achieving the target of reducing death rates from noncommunicable diseases by 2% annually for the next 10 years, as contained in the Eleventh General Programme of Work, 2006–2015;¹
- (2) to establish or to strengthen a national coordinating mechanism for prevention of noncommunicable diseases where appropriate to national circumstances, with a broad multisectoral mandate including mobilization of political will and financial resources, and involving all relevant stakeholders;
- (3) to develop and implement a national multisectoral evidence-based action plan for prevention and control of noncommunicable diseases that sets out priorities, a time frame and performance indicators, provides the basis for coordinating the work of all stakeholders, and actively engages civil society, while ensuring avoidance of potential conflict of interest;

¹ Document A59/25, Appendix 6.

(4) to increase, as appropriate, resources for programmes for the prevention and control of noncommunicable diseases;

(5) to implement and increase support for existing global initiatives and the Framework Convention on Tobacco Control that contribute to achieving the target of reducing death rates from noncommunicable diseases by 2% annually for the next ten years;

(6) to make prevention and control of noncommunicable diseases an integral part of programmes aimed at strengthening primary health-care systems, and to strengthen primary health care institutions so that they respond to the challenges raised by noncommunicable diseases;

(7) to strengthen monitoring and evaluation systems, including country-level epidemiological surveillance mechanisms, in order to compile evidence for informing policy decisions;

(8) to ensure that health institutions are adequately organized in order to address the serious challenges raised by noncommunicable diseases, which implies a particular focus on primary health care;

(9) to emphasize the key role of governmental functions, including regulatory functions, when combating noncommunicable diseases;

(10) to increase access to medicines for high-risk populations in low- and middle-income countries;

2. REQUESTS the Director-General:

(1) on the basis of an outline contained in the report on prevention and control of noncommunicable diseases: implementation of the global strategy,¹ to prepare an action plan to be submitted to the Sixty-first World Health Assembly, through the Executive Board, that sets out priorities, actions, a time frame and performance indicators for prevention and control of noncommunicable diseases between 2008 and 2013 at global and regional levels, and to provide support where needed for elaboration, intensified implementation and monitoring of national plans for prevention and control of noncommunicable diseases, including the further development of an intervention to manage the conditions of people at high risk of such diseases;

(2) to raise further awareness among Member States of the importance of drawing up, promoting and funding supportive national multisectoral coordination and surveillance mechanisms, and plans for prevention and control of noncommunicable diseases;

(3) to provide support to Member States, on request, and to foster partnership, collaboration, cooperation and sharing of best practices among Member States for incorporating comprehensive noncommunicable disease interventions into national policies and programmes, including health systems policies and programmes, and for expanding interventions, including strategies to educate and support individuals and families;

¹ Document EB120/22.

- (4) to disseminate to Member States, in a timely and consistent manner, information on cost-effective, core interventions aimed at preventing and controlling noncommunicable diseases;
- (5) to encourage dialogue with international, regional and national nongovernmental organizations, donors and technical-agency partners and the private sector, while ensuring the avoidance of potential conflict of interest, in order to increase support, resources and partnerships for prevention and control of noncommunicable diseases, including health and wellness programmes at the workplace as appropriate;
- (6) to promote initiatives aimed at implementing the global strategy in order to increase availability of healthy foods and encourage healthy diets, and to promote responsible marketing in order to reduce the impact of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt, in dialogue with all relevant stakeholders, including private-sector parties, while ensuring avoidance of potential conflict of interest;
- (7) to build and sustain contact with the mass media in order to ensure continued prominence in the media of issues related to the prevention and control of noncommunicable diseases;
- (8) to improve understanding of the socioeconomic impact of noncommunicable diseases at national and household levels, especially in low- and middle-income countries;
- (9) to ensure that the work on prevention and control of noncommunicable diseases is given suitably high priority and support where appropriate;
- (10) to report to the Sixty-third World Health Assembly, and subsequently every two years to the Health Assembly, through the Executive Board, on progress in implementing the global strategy on prevention and control of noncommunicable diseases, including progress on the action plan.

(Twelfth meeting, 29 January 2007)

EB120.R18 Scale of assessments 2008–2009

The Executive Board,

Having considered the report on Scale of assessments 2008–2009,¹

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:

The Sixtieth World Health Assembly,

Having considered the report of the Director-General,

ADOPTS the scale of assessments of Members for the biennium 2008–2009 as set out below:

¹ See Annex 2.

Members and Associate Members	WHO scale for 2008–2009 %
Afghanistan	0.0010
Albania	0.0060
Algeria	0.0850
Andorra	0.0080
Angola	0.0030
Antigua and Barbuda	0.0020
Argentina	0.3250
Armenia	0.0020
Australia	1.7871
Austria	0.8871
Azerbaijan	0.0050
Bahamas	0.0160
Bahrain	0.0330
Bangladesh	0.0100
Barbados	0.0090
Belarus	0.0200
Belgium	1.1021
Belize	0.0010
Benin	0.0010
Bhutan	0.0010
Bolivia	0.0060
Bosnia and Herzegovina	0.0060
Botswana	0.0140
Brazil	0.8761
Brunei Darussalam	0.0260
Bulgaria	0.0200
Burkina Faso	0.0020
Burundi	0.0010
Cambodia	0.0010
Cameroon	0.0090
Canada	2.9772
Cape Verde	0.0010
Central African Republic	0.0010
Chad	0.0010
Chile	0.1610
China	2.6672
Colombia	0.1050
Comoros	0.0010
Congo	0.0010
Cook Islands	0.0010
Costa Rica	0.0320
Côte d'Ivoire	0.0090
Croatia	0.0500
Cuba	0.0540
Cyprus	0.0440
Czech Republic	0.2810
Democratic People's Republic of Korea	0.0070
Democratic Republic of the Congo	0.0030
Denmark	0.7391
Djibouti	0.0010

Members and Associate Members	WHO scale for 2008–2009 %
Dominica	0.0010
Dominican Republic	0.0240
Ecuador	0.0210
Egypt	0.0880
El Salvador	0.0200
Equatorial Guinea	0.0020
Eritrea	0.0010
Estonia	0.0160
Ethiopia	0.0030
Fiji	0.0030
Finland	0.5640
France	6.3015
Gabon	0.0080
Gambia	0.0010
Georgia	0.0030
Germany	8.5777
Ghana	0.0040
Greece	0.5960
Grenada	0.0010
Guatemala	0.0320
Guinea	0.0010
Guinea-Bissau	0.0010
Guyana	0.0010
Haiti	0.0020
Honduras	0.0050
Hungary	0.2440
Iceland	0.0370
India	0.4500
Indonesia	0.1610
Iran (Islamic Republic of)	0.1800
Iraq	0.0150
Ireland	0.4450
Israel	0.4190
Italy	5.0794
Jamaica	0.0100
Japan	16.6253
Jordan	0.0120
Kazakhstan	0.0290
Kenya	0.0100
Kiribati	0.0010
Kuwait	0.1820
Kyrgyzstan	0.0010
Lao People's Democratic Republic	0.0010
Latvia	0.0180
Lebanon	0.0340
Lesotho	0.0010
Liberia	0.0010
Libyan Arab Jamahiriya	0.0620
Lithuania	0.0310
Luxembourg	0.0850

Members and Associate Members	WHO scale for 2008–2009 %
Madagascar	0.0020
Malawi	0.0010
Malaysia	0.1900
Maldives	0.0010
Mali	0.0010
Malta	0.0170
Marshall Islands	0.0010
Mauritania	0.0010
Mauritius	0.0110
Mexico	2.2572
Micronesia (Federated States of)	0.0010
Monaco	0.0030
Mongolia	0.0010
Montenegro	0.0010
Morocco	0.0420
Mozambique	0.0010
Myanmar	0.0050
Namibia	0.0060
Nauru	0.0010
Nepal	0.0030
Netherlands	1.8731
New Zealand	0.2560
Nicaragua	0.0020
Niger	0.0010
Nigeria	0.0480
Niue	0.0010
Norway	0.7821
Oman	0.0730
Pakistan	0.0590
Palau	0.0010
Panama	0.0230
Papua New Guinea	0.0020
Paraguay	0.0050
Peru	0.0780
Philippines	0.0780
Poland	0.5010
Portugal	0.5270
Puerto Rico	0.0010
Qatar	0.0850
Republic of Korea	2.1732
Republic of Moldova	0.0010
Romania	0.0700
Russian Federation	1.2001
Rwanda	0.0010
Saint Kitts and Nevis	0.0010
Saint Lucia	0.0010
Saint Vincent and the Grenadines	0.0010
Samoa	0.0010
San Marino	0.0030
Sao Tome and Principe	0.0010

Members and Associate Members	WHO scale for 2008–2009 %
Saudi Arabia	0.7481
Senegal	0.0040
Serbia	0.0210
Seychelles	0.0020
Sierra Leone	0.0010
Singapore	0.3470
Slovakia	0.0630
Slovenia	0.0960
Solomon Islands	0.0010
Somalia	0.0010
South Africa	0.2900
Spain	2.9682
Sri Lanka	0.0160
Sudan	0.0100
Suriname	0.0010
Swaziland	0.0020
Sweden	1.0711
Switzerland	1.2161
Syrian Arab Republic	0.0160
Tajikistan	0.0010
Thailand	0.1860
The former Yugoslav Republic of Macedonia	0.0050
Timor-Leste	0.0010
Togo	0.0010
Tokelau	0.0010
Tonga	0.0010
Trinidad and Tobago	0.0270
Tunisia	0.0310
Turkey	0.3810
Turkmenistan	0.0060
Tuvalu	0.0010
Uganda	0.0030
Ukraine	0.0450
United Arab Emirates	0.3020
United Kingdom of Great Britain and Northern Ireland	6.6425
United Republic of Tanzania	0.0060
United States of America	22.0000
Uruguay	0.0270
Uzbekistan	0.0080
Vanuatu	0.0010
Venezuela (Bolivarian Republic of)	0.2000
Viet Nam	0.0240
Yemen	0.0070
Zambia	0.0010
Zimbabwe	0.0080
Total	100.0000

(Twelfth meeting, 29 January 2007)

EB120.R19 Director-General and Deputy Director-General of the World Health Organization: review of matters arising from the special and 118th sessions of the Executive Board

The Executive Board,

Having considered the proposals contained in the report on the Director-General and Deputy Director-General of the World Health Organization: review of matters arising from the special and 118th sessions of the Executive Board:¹

1. AGREES with the procedure developed by the Secretariat as to the manner in which the Executive Board assesses whether the candidate nominated by it for the post of Director-General has the good physical condition required of all staff members of the Organization;
2. DECIDES that the curriculum vitae and supporting information of each candidate proposed under Rule 52 of the Rules of Procedure of the Executive Board shall be limited to 2000 words and shall also be submitted in electronic format to enable the Chairman of the Board to verify that this limit is not exceeded;
3. CONFIRMS its previous decision that the curriculum vitae should address the criteria established by the Executive Board, and include a statement on the vision of the candidate on priorities and strategies;²
4. DECIDES that the Chairman of the Board may authorize the Director-General to post on WHO's web site, in addition to the names of the candidates, the curricula vitae and other supporting information as dispatched to Member States, and contact information for each candidate, unless the candidate concerned or the Member State that proposed him or her stipulates otherwise;
5. REQUESTS the Director-General to report to the Executive Board at its 121st session on the geographical rotation of the post of Director-General, and on the requirement to appoint a Deputy Director-General, taking into account the views expressed by members of the Board.

(Thirteenth meeting, 29 January 2007)

EB120.R20 Relations with nongovernmental organizations³

The Executive Board,

Having examined the report of its Standing Committee on Nongovernmental Organizations,⁴

1. DECIDES to admit into official relations with WHO the World Plumbing Council, The International Society for Quality in Health Care Incorporated, World Association for Sexual Health, The International Federation of Anti-Leprosy Associations, International Association of Medical Regulatory Authorities, International Alliance of Patients' Organizations, and EuroSafe – European Association for Injury Prevention and Safety Promotion;

¹ See Annex 3.

² Decision EB100(7).

³ See Annex 4.

⁴ Document EB120/41.

2. DECIDES to discontinue official relations with the following nongovernmental organizations: International Federation of Sports Medicine, International Society for the Study of Behavioural Development and the International Traffic Medicine Association.

(Thirteenth meeting, 29 January 2007)

EB120.R21 Health technologies

The Executive Board,

Having considered the report on essential health technologies,¹

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:²

The Sixtieth World Health Assembly,

Having considered the report on health technologies;

Recognizing that health technologies equip health-care providers with tools that are indispensable for effective and efficient prevention, diagnosis, treatment and rehabilitation and attainment of internationally agreed health-related development goals, including those contained in the Millennium Declaration;

Understanding that health technologies represent an economic as well as a technical challenge to the health systems of many Member States, and concerned about the waste of resources resulting from inappropriate investments in health technologies that do not meet high-priority needs, are incompatible with existing infrastructures, are irrationally or incorrectly used, or do not function efficiently;

Acknowledging the need for Member States and donors to contain burgeoning costs by establishing priorities in the selection and acquisition of health technologies on the basis of their impact on the burden of disease, and to ensure the effective use of resources through proper planning, assessment, acquisition and management,

1. URGES Member States:

- (1) to collect, verify, update and exchange information on health technologies as an aid to their prioritization of needs and allocation of resources;
- (2) to formulate as appropriate national strategies and plans for the establishment of systems for the assessment, procurement and management of health technologies;
- (3) to draw up national guidelines for good manufacturing and regulatory practices, to establish surveillance systems and other measures to ensure the quality, safety and efficacy of medical devices;

¹ Document EB120/13.

² See Annex 3 for the financial and administrative implications for the Secretariat of this resolution.

(4) to establish where necessary regional and national institutes of health technology, and to collaborate and build partnerships with health-care providers, industry, patients' associations and professional, scientific and technical organizations;

2. REQUESTS the Director-General:

(1) to work with interested Member States and WHO collaborating centres on the development, in a transparent and evidence-based way, of guidelines and tools, including norms and standards, relating to health technologies;

(2) to provide support to Member States where necessary in establishing mechanisms to assess national needs for health technologies and to assure their availability and use;

(3) to provide technical guidance and support to Member States where necessary in implementing policies on health technologies;

(4) to work jointly with other organizations of the United Nations system, international organizations, academic institutions and professional bodies in order to provide support to Member States in the prioritization, selection and use of health technologies;

(5) to report on implementation of this resolution to the Sixty-second World Health Assembly.

(Thirteenth meeting, 29 January 2007)

DECISIONS

EB120(1) Confirmation by the United Nations General Assembly of the International Civil Service Commission's general framework, including implementation and cost of amendments to the Staff Rules

The Executive Board, having considered the report on confirmation by the United Nations General Assembly of the International Civil Service Commission's general framework, including implementation, and cost of amendments to the Staff Rules: postponement of effective date of amendments to the Staff Rules,¹ decided that:

- (1) with the exception of the amendments to the Staff Rules on the mobility and hardship allowance and assignment grant as they apply to staff members holding career service/service and fixed-term appointments, the amendments to the Staff Rules that the Executive Board confirmed at its 118th session in May 2006, with effect from 1 January 2007, subject to the endorsement by the United Nations General Assembly of the general framework recommended by the International Civil Service Commission, are confirmed, with effect from 1 July 2007; such amendments being subject to transitional measures determined by the Director-General;
- (2) the aforesaid amendments to the Staff Rules on the mobility and hardship allowance and assignment grant as they apply to staff members holding career service/service and fixed-term appointments are confirmed, with effect from 1 January 2007.

(Twelfth meeting, 29 January 2007)

EB120(2) Review of nongovernmental organizations in official relations with WHO

The Executive Board, having considered the report of its Standing Committee on Nongovernmental Organizations on the review of one third of the nongovernmental organizations in official relations with WHO,² and following up decision EB117(3), reached the decisions set out below.

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

Noting that reports had not been received, had been received too late, or that further information was required, the Board decided to defer until its 122nd session the review of relations with the following nongovernmental organizations: Aga Khan Foundation, Commonwealth Medical Association, International Association of Cancer Registries, International Catholic Committee of Nurses and Medico-social Assistants, International League of Dermatological Societies, International

¹ See Annex 5.

² See Annex 4.

Conference of Deans of French-Language Faculties of Medicine, International Epidemiological Association, International Federation of Biomedical Laboratory Science, International Federation of Medical Students Associations, International Medical Informatics Association, International Society for Burn Injuries, International Society of Hematology, International Union of Microbiological Societies, OXFAM, World Federation for Ultrasound in Medicine and Biology, and World Vision International.

Noting that plans for collaboration between WHO and the International Association of Logopedics and Phoniatrics, and the World Veterinary Association, had been agreed, the Board decided to maintain these nongovernmental organizations in official relations with WHO.

Noting the continuing expectation that plans for collaboration between WHO and the World Federation of Nuclear Medicine and Biology, and the World Organization of the Scout Movement, would be agreed, the Board decided to defer the review of relations with these nongovernmental organizations until its 122nd session.

Noting the information received from Corporate Accountability International, the Board decided to maintain that organization in official relations with WHO and requested the Secretariat, when informing the organization of this decision, to mention the importance of conduct that is consistent with the privileges accorded to nongovernmental organizations in official relations with WHO.

Noting that reports of collaboration remained outstanding from the following nongovernmental organizations: the International Commission on Radiological Protection, International Federation for Housing and Planning, International Society for Environmental Epidemiology, International Society for Preventive Oncology, and the International Society of Nurses in Cancer Care, the Board decided to defer for a further year the review of the relations of those organizations with WHO and that they should be informed that, should the reports not be forthcoming for consideration by the Executive Board at its 122nd session, their official relations would be discontinued.

Noting the information provided by the International Society for Biomedical Research on Alcoholism concerning efforts to resume planned collaboration with WHO, and taking into consideration the organization's request for the continuance of official relations, the Board decided to maintain the Society in official relations with WHO for a further year in order to allow time for the parties to agree on a plan for collaboration to be reviewed by the Board at its 122nd session.

The Board decided to maintain the International Confederation of Midwives in official relations with WHO for a further year on the condition that the Confederation would, within three months of being informed of this decision, confirm its intention to submit a report for consideration by the Executive Board at its 122nd session. If such confirmation were not received within the three-month period, official relations would be discontinued.

(Thirteenth meeting, 29 January 2007)

EB120(3) Measures to be taken for facilitating the participation of nongovernmental organizations in the work of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property

The Executive Board, having considered the recommendation of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property¹ and the report of the Standing Committee on Nongovernmental Organizations,² authorized the Chairman of the Executive Board, acting jointly with the Chairman of the Standing Committee, to admit provisionally nongovernmental organizations into official relations with WHO. The facility established by the present decision will apply to nongovernmental organizations that request official relations solely, or also, for the purpose of participating in the work of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property, subject to the following conditions and requirements:

- (1) nongovernmental organizations must be in working relations with WHO at the time of submission of their application, so that approximately two years of working relations will have elapsed by the time the Executive Board formally reviews their applications under point (3) below, and must otherwise meet the criteria established in section 3 of the Principles Governing Relations between the World Health Organization and Nongovernmental Organizations;³
- (2) the mandates of the nongovernmental organizations concerned must be relevant to the work of the Intergovernmental Working Group;
- (3) the Executive Board will review nongovernmental organizations in provisional official relations at its January session subsequent to their admission into provisional official relations, for the purpose of confirming or terminating such relations in accordance with normal procedures.

This decision will remain applicable, unless terminated or revised by the Board, until the completion of the work of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property.

(Thirteenth meeting, 29 January 2007)

EB120(4) Award of the Dr A.T. Shousha Foundation Prize

The Executive Board, having considered the report of the Dr A.T. Shousha Foundation Committee, awarded the Dr A.T. Shousha Foundation Prize for 2007 to Dr Nabil Kronfol (Lebanon) for his significant contribution to public health in the Eastern Mediterranean Region. The laureate will receive the equivalent of 2500 Swiss francs in United States dollars.

(Thirteenth meeting, 29 January 2007)

¹ Contained in document EB120/35 Add.1, Section F.

² Document EB120/41.

³ In *Basic Documents*, 45th ed. Geneva, World Health Organization, 2005.

EB120(5) Award of the Léon Bernard Foundation Prize

The Executive Board, having considered the report of the Léon Bernard Foundation Committee, awarded the Léon Bernard Foundation Prize for 2007 to Dr Than Tun Sein (Myanmar) for his outstanding service in the field of social medicine. The laureate will receive a bronze medal and the sum of 2500 Swiss francs.

(Thirteenth meeting, 29 January 2007)

EB120(6) Award of the Ihsan Dogramaci Family Health Foundation Prize

The Executive Board, having considered the report of the Ihsan Dogramaci Family Health Foundation Selection Panel, awarded the Ihsan Dogramaci Family Health Foundation Prize for 2007 jointly to Mrs Mehriban Aliyeva (Azerbaijan) and Maestra Guillermina Natera Rey (Mexico) for their service in the field of family health. The laureates will each receive US\$ 10 000.

(Thirteenth meeting, 29 January 2007)

EB120(7) 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 2007 to Dr Jose Antonio Socrates (Philippines) for his outstanding innovative work in health development. The laureate will receive US\$ 30 000.

(Thirteenth meeting, 29 January 2007)

EB120(8) 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 2007 to the Bill & Melinda Gates Foundation (United States of America) for its outstanding contribution to health development. The laureate will receive US\$ 40 000.

(Thirteenth meeting, 29 January 2007)

EB120(9) Award of the State of Kuwait Prize for Research in Health Promotion

The Executive Board, having considered the report of the State of Kuwait Health Promotion Foundation Selection Panel, decided not to award the State of Kuwait Prize for Research in Health Promotion in 2007.

(Thirteenth meeting, 29 January 2007)

EB120(10) Provisional agenda for, and duration of, the Sixtieth World Health Assembly

The Executive Board, having considered the report of the Director-General on the provisional agenda for the Sixtieth World Health Assembly,¹ and recalling its earlier decision that the Sixtieth World Health Assembly should be held at the Palais des Nations in Geneva, opening on Monday, 14 May 2007, and closing no later than Wednesday, 23 May 2007,² approved the provisional agenda of the Sixtieth World Health Assembly, as amended.

(Thirteenth meeting, 29 January 2007)

EB120(11) Date and place of the 121st session of the Executive Board

The Executive Board decided that its 121st session should be convened on Thursday, 24 May 2007, at WHO headquarters, Geneva, and should close no later than Saturday, 26 May 2007.

(Thirteenth meeting, 29 January 2007)

¹ Document EB120/32.

² See decision EB118(5).

ANNEXES

ANNEX 1

Confirmation of amendments to the Staff Rules¹

Report by the Secretariat

[EB120/29–11 January 2007]

1. Amendments to the Staff Rules made by the Acting Director-General are submitted for confirmation by the Board in accordance with Staff Regulation 12.2.²
2. The amendments described in section I of this document stem from decisions expected to be taken by the United Nations General Assembly at its sixty-first session, on the basis of recommendations made by the International Civil Service Commission. Should the United Nations General Assembly not approve the recommendations that have resulted in the amendments in section I, an addendum to this document will be issued.
3. The amendments described in section II of this document have been made in the light of experience and in the interests of good human resources management.
4. The financial implications of the amendments in the biennium 2006–2007 include negligible additional costs under the regular budget, which will be met from the appropriate allocations established for each of the Regions and for global and interregional activities, and from extrabudgetary sources of funds.
5. The amended Staff Rules are set out in the Appendix.

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

Remuneration of staff in the professional and higher categories

6. The Commission informed the United Nations General Assembly that its present recommendation superseded its 2005 base/floor recommendation, which had not been acted on by the Assembly, and reflected the movement of comparator net salaries in the two-year period 2005–2006.

¹ See resolution EB120.R10.

² *Basic documents*, 45th ed., Geneva, World Health Organization, 2005.

7. In that context, the Commission recommended to the United Nations General Assembly that:

(a) The current base/floor salary scale for the professional and higher categories be increased by 4.57% through the standard consolidation procedures on the basis of the standard method of reducing post adjustment multiplier points and increasing net salary, i.e. on a no loss/no gain basis, with effect from 1 January 2007;

(b) The new arrangements for the mobility and hardship scheme, as recommended to the Assembly in the report of the Commission for 2005,¹ be introduced concurrently with the adjustment of the base/floor salary scale, that is, as from 1 January 2007.²

8. Amendments to Appendix 1 of the Staff Rules have been prepared accordingly (see Attachment).

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

9. Subject to the decision of the United Nations General Assembly in respect of the recommendation in paragraph 7 above, the Acting Director-General proposes, in accordance with Staff Regulation 3.1, that the Executive Board recommend to the Sixtieth World Health Assembly modifications in the salaries of Assistant Directors-General and Regional Directors. Thus, as of 1 January 2007, the gross salary for Assistant Directors-General and Regional Directors would be US\$ 168 826 per annum, and the net salary US\$ 122 737 (dependency rate) or US\$ 111 142 (single rate).

10. Based on the adjustments to salaries described above, the salary to be authorized by the Health Assembly for the Deputy Director-General would be: (i) as of 1 January 2006, a gross salary of US\$ 181 778 per annum and a corresponding net salary of US\$ 131 156 (dependency rate) or US\$ 118 034 (single rate); and (ii) as from 1 January 2007, a gross salary of US\$ 185 874 per annum with a corresponding net salary of US\$ 133 818 (dependency rate) or US\$ 120 429 (single rate).

11. The salary adjustments described above would imply similar adjustments to the salary of the Director-General. The modification in salary to be authorized by the Health Assembly as from 1 January 2007 would therefore be US\$ 228 818 per annum gross, US\$ 161 732 net (dependency rate) or US\$ 143 829 (single rate).

Education grant

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

(a) In Denmark, Ireland, Italy, Sweden, the United States of America and the United States dollar area outside the United States, the maximum admissible expenses and the maximum education grant should be set as shown in annex II, table 1, of its report for 2006;³

¹ *Official Records of the General Assembly, Sixtieth Session, Supplement No. 30 and corrigendum (A/60/30 and Corr. 1), Annex II.*

² The amendments to Staff Rules resulting from the proposed new mobility and hardship allowance scheme were submitted to the Board for confirmation in May 2006 (document EB118/11).

³ *Official Records of the General Assembly, Sixty-first session, Supplement No. 30 (A/61/30).*

(b) The maximum admissible expenses and the maximum education grant should remain at the current levels for Austria, Belgium, Finland, France (subject to subparagraph (d) below), Germany, Japan, the Netherlands, Spain, Switzerland and the United Kingdom, as shown in annex II, table 2 of its report for 2006;

(c) The separate zone of Norway should be discontinued and the education claims for that country included in the United States dollar area outside the United States;

(d) A separate maximum admissible expense level equal to that applicable to the United States of America should be established for the following schools in France: American School of Paris; British School of Paris; International School of Paris; American University of Paris; Marymount School of Paris; European Management School of Lyon;

(e) The flat rates for boarding should be taken into account within the maximum admissible educational expenses and the additional amounts for reimbursement of boarding costs over and above the maximum grant payable to staff members at designated duty stations should be revised as shown in annex II, table 3 of its report for 2006;

(f) The amount of the special education grant for each disabled child should be equal to 100% of the revised amounts of the maximum allowable expenses for the regular grant;

(g) Special measures should be maintained for China, Indonesia and the Russian Federation, which would allow organizations to reimburse 75% of actual expenses up to and not exceeding the level of the maximum admissible expenses in force for the United States dollar area inside the United States of America. In the course of its discussion, the Commission agreed that the special measure for Romania could be discontinued.

13. The Commission further recommended that all of the above measures should be applicable as from the school year in progress on 1 January 2007.

14. The Commission also recommended to the United Nations General Assembly that the eligibility period for the education grant should continue up to the end of the school year in which the child completes four years of post-secondary studies even if a degree had been attained after three years and students would continue to be subject to the age limit of 25 years.

15. Amendments to Staff Rule 350.1.1 and to Appendix 2 to the Staff Rules (see Attachment) have been prepared accordingly.

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

Home leave

(a) Home leave destination

16. Staff Rule 640.1 has been amended to allow staff members and their families to take home leave in a country other than that of the staff member's recognized place of residence. The intention is to recognize situations where staff members and their families are of multicultural backgrounds and where, during the course of their careers, they have established cultural/family ties in places other than their country of nationality/recognized place of residence. An editorial change has been made to Staff

Rule 640.1 to clarify that the period spent on home leave is charged to the staff member's annual leave entitlement.

17. Staff Rule 640.5 has been amended to reflect the changes to Staff Rule 640.1, and to clarify the Organization's financial liability when home leave is taken in a country other than that of the staff member's recognized place of residence. Staff Rules 640.5.1 and 640.5.2 have also been amended to reflect the amendments to Staff Rule 640.1.

18. The above changes serve to align WHO Staff Rules and policies with those recently adopted by the United Nations and which were already in place in other organizations in the United Nations common system.

(b) Frequency of home leave

19. Staff Rules 640.3.2 and 640.6.4 have been amended to reduce the service time requirement after home leave to three months in the case of staff members serving in 12-month duty stations. Staff Rule 640.6.3 has been deleted to remove the requirement that eligible family members travel on home leave at the same time as the staff member. Staff Rules 640.6.4 and 640.6.5 have been renumbered accordingly.

20. The above changes serve to align WHO Staff Rules and policies with those of the United Nations and other organizations in the United Nations common system, and to recognize the mobile and international nature of the workforce and the difficult working and living conditions of staff members serving in hardship duty stations.

Special leave

21. Staff Rule 650 has been amended to allow the Director-General to determine the conditions, including duration, under which special leave under this Rule may be granted. It has also been edited in the interest of clarity and further amended to refer specifically to leave for child care and serious illness of family members as important reasons for which special leave may be granted, and to provide that in such exceptional cases, including the death of an immediate family member, annual leave need not be exhausted before special leave is taken.

22. These changes serve to align WHO's Staff Rules with those of the United Nations and other organizations in the United Nations common system.

Leave without pay

23. New Staff Rule 655.3 has been introduced to allow the Director-General to authorize leave without pay for pension purposes for staff who are within two years of reaching age 55 and 25 years of contributory service, or who are over that age and within two years of 25 years of contributory service. Staff Rule 655.1 on leave without pay has been amended to reflect new Staff Rule 655.3.

24. These changes serve to align WHO's Staff Rules with those of the United Nations and other organizations in the United Nations common system.

Leave for military training or service

25. Staff Rule 660.1 has been amended to provide for special leave for up to the full duration of the military training or service.

Sick leave (family emergency leave)

26. Staff Rule 740.2 has been amended to allow staff members to use part or all of the family-emergency leave entitlement (seven working days of uncertified sick leave) in the event of the death of an immediate family member.

27. This change serves to align WHO's Staff Rules with those of the United Nations and other organizations in the United Nations common system.

Maternity leave

28. Staff Rule 760.2 has been amended to provide for an additional four weeks of maternity leave in the case of multiple births. While this is not policy in other organizations, it is important that WHO, as the leading Organization in health, sets the health standard in these exceptional circumstances in the best interests of staff well-being and good human resources management. Editorial changes have been made to Staff Rule 760.4 for greater clarity.

Paternity leave and adoption leave

29. Given that paternity leave and adoption leave are distinct forms of leave with full pay, new Staff Rule 763 on paternity leave and new Staff Rule 765 on adoption leave have been introduced. Accordingly, Staff Rules 760 and 760.1 on maternity leave have been amended to remove the references to paternity leave. Staff Rule 760.5 on paternity leave has been renumbered and reflected as new Staff Rule 763, and editorial changes made for greater clarity.

30. Staff Rule 650 on special leave has been amended to remove the reference to adoption leave.

Travel of staff members

31. Staff Rule 810.5.2 has been amended to reduce the service time requirement after family visit travel in the case of staff members serving in 12-month duty stations. In addition, the reference in Staff Rule 810.5.4 to Staff Rule 640.6.5 has been changed to renumbered Staff Rule 640.6.4.

32. This change serves to recognize the difficult working and living conditions of staff members serving in difficult duty stations.

Travel of children under the education grant

33. Staff Rule 820.2.5.2 has been amended to permit children with an entitlement to travel under the education grant to reunite with the staff member at a place other than the staff member's duty station or the child's place of study.

34. This change serves to align WHO Staff Rules and policies with those of the United Nations and other organizations in the United Nations common system.

Resignation

35. Staff Rule 1010.3 has been amended and new Staff Rule 1010.4 introduced to reflect the amendments to Staff Rules 640.3.2, 640.6.4 and 810.5.2.

Completion of appointments

36. New Staff Rule 1040.2 has been introduced to provide for the extension of an appointment when it expires during maternity leave, paternity leave or adoption leave. Such appointment extension will be for a period determined, and under conditions established, by the Director-General. Staff Rule 1040 has been renumbered accordingly, and an editorial change made in the interest of clarity.

37. These changes serve to align WHO's Staff Rules with those of the United Nations and other organizations in the United Nations common system.

Notice of termination

38. Staff Rule 1083 has been amended to provide that notice of termination under Staff Rules 1030, 1045, 1050, 1060, 1070 and 1080 may be served during periods of maternity leave, paternity leave or adoption leave. The effective date of termination will be either the expiry date of the leave, or the end of the notice period under the relevant Staff Rule, whichever is later.

Effective date of termination

39. Staff Rule 1090 has been amended, and new Staff Rules 1090.1 and 1090.2 introduced to reflect the amendments to Staff Rule 1083.

ACTION BY THE EXECUTIVE BOARD

40. [This paragraph contained two draft resolutions, which were adopted at the twelfth meeting as resolution EB120.R10 and resolution EB120.R11, respectively.]

Appendix

TEXT OF AMENDED STAFF RULES

350. EDUCATION GRANT

350.1 Internationally recruited staff members shall be entitled to an education grant, except as indicated in Rule 350.3, under the conditions which follow:

350.1.1 the grant is payable for each child as defined under Rule 310.5.2 up to the end of the school year in which the child reaches the age of 25 or completes four years of post-secondary studies, whichever is earlier;

.....

640. HOME LEAVE

640.1 Home leave is provided so that a staff member who is serving and residing outside the country of his recognized place of residence may spend a reasonable period of annual leave in his home country with a view to maintaining effective association with his culture, with his family, and with his national, professional or other interests. Staff members may exercise home leave travel in a country other than that of their recognized place of residence under conditions established by the Director-General.

...

640.3 Staff members are eligible for home leave when:

640.3.1 they are serving and residing outside the country of their recognized place of residence as established under Rule 460; and

640.3.2 if the staff member is assigned to a 24-month official station, their service is expected to continue at least six months beyond the date of return from home leave or six months beyond the date of eligibility for home leave, whichever is later, or, if the staff member is assigned to a 12-month official station, their service is expected to continue at least three months beyond the date of return from home leave or three months beyond the date of eligibility for home leave, whichever is later; and

...

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 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 official station, or for at least three months if the staff member is assigned to a 12-month official 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 children, and in relation to the exigencies of the service.

650. SPECIAL LEAVE

Special leave with full, partial or no pay may be granted at the request of a staff member for such period and under such conditions as the Director-General may prescribe. This special leave may be granted for training or research in the interest of the Organization or for other important reasons, including but not limited to child care, serious illness of a family member, or death of an immediate family member. The Director-General may, at his or her initiative, place a staff member on special leave with full pay if he or she considers such leave to be in the interest of the Organization. Normally, such leave shall not be granted until all accrued annual leave has been exhausted, except in the cases of special leave to care for a child, serious illness of a family member or death of an immediate family member. Continuity of service shall not be broken during periods of special leave, which shall be credited for all purposes except as otherwise specified in the Rules.

655. LEAVE WITHOUT PAY

655.1 Leave without pay may be granted, for a period normally not in excess of one year, except as indicated in Rule 655.3 below, for purposes normally covered by sick or annual leave when that leave has been exhausted.

...

655.3 The Director-General may authorize leave without pay for pension purposes for staff who are within two years of reaching age 55 and 25 years of contributory service, or who are over that age and within two years of reaching 25 years of contributory service.

660. LEAVE FOR MILITARY TRAINING OR SERVICE

660.1 Upon application, staff members, except those holding temporary appointments as defined in 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 the provisions of Rule 655.2 shall apply.

740. SICK LEAVE

...

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

760. MATERNITY LEAVE

- 760.1 Staff members shall be entitled to maternity leave, subject to conditions established by the Director-General.

- 760.2 Maternity leave shall commence six weeks before the expected date of birth upon submission of a certificate from a duly qualified medical practitioner or midwife indicating the expected due date. At the request of the staff member and on medical advice, the Director-General may permit the maternity leave to commence less than six weeks but not less than two weeks before the expected due date. Maternity leave shall extend for a period of 16 weeks from the time it is granted, except that in the case of multiple births, maternity leave shall extend for a period of 20 weeks from the time it is granted. However, in no case shall maternity leave terminate less than 10 weeks after the actual date of birth. The leave is paid with full salary and allowances.

...

- 760.4 Where both parents of a newborn child are staff members of the World Health Organization, any unused portion of maternity leave to which the mother would otherwise have been entitled under Rule 760.2 may be used by the other parent, under conditions established by the Director-General.

...

763. PATERNITY LEAVE

A staff member shall be entitled to paternity leave subject to conditions established by the Director-General. Upon presentation of satisfactory evidence of the birth of the staff member's child, the staff member shall be entitled to paternity leave for a total period of up to four weeks or, in the case of internationally recruited staff members serving at a non-family duty station, up to eight weeks. In exceptional circumstances, leave shall be granted for a total period of up to eight weeks. Paternity leave must be exhausted within 12 months from the date of the child's birth.

...

765. ADOPTION LEAVE

Subject to conditions established by the Director-General, and upon presentation of satisfactory evidence of the adoption of a child, a staff member shall be entitled to adoption leave for a total period of eight weeks.

810. TRAVEL OF STAFF MEMBERS

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

...

810.5.2 his assignment is to continue for at least six months after his return if the staff member is assigned to a 24-month official station or for at least three months if the staff member is assigned to a 12-month official station;

...

810.5.4 there is a reasonable interval between this travel and travel on home leave (see also Rule 640.6);

820. TRAVEL OF SPOUSE AND CHILDREN

...

820.2.5 for a child for whom there is an entitlement to an education grant under Rule 350 for study outside the commuting distance of the official station, provided Rule 655.2.4 does not apply:

...

820.2.5.2 one round trip each scholastic year between the place of study and the official station or other place, if:

(1) the duration of the child's visit to the parents is reasonable in relation to the amount of travel expenses borne by the Organization;

(2) the travel expenses to be borne by the Organization do not exceed the cost of round-trip travel between the official station and the staff member's recognized place of residence, or the destination of the travel, whichever is less;

(3) the timing of the child's journey is reasonable in relation to other authorized travel of the staff member, spouse, or children;

1010. RESIGNATION

...

1010.3 A staff member assigned to a 24-month official 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 the later, or from travel under Rule 810.5, forfeits entitlement to repatriation travel at the Organization's expense for himself and family members who accompanied him on such travel. In case the staff member exercises his entitlement under 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 official 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 the later, or from travel under Rule 810.5, forfeits entitlement to repatriation travel at the Organization's expense for himself and family members who accompanied him on such travel. In the event that the staff member exercises his entitlement under 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.

1040. COMPLETION OF APPOINTMENTS

1040.1 In the absence of any offer and acceptance of extension, fixed-term and temporary appointments shall expire automatically on the completion of the agreed period of service. Where it has been decided not to offer an extension of appointment to a staff member holding a fixed-term appointment, the staff member shall be notified thereof no less than three months before the expiry of the appointment. Where it has been decided not to offer an extension of appointment to a staff member holding a temporary appointment, the staff member shall be notified thereof normally no less than one month before the expiry of the appointment. Such notice shall not be required in the case of a staff member holding a temporary appointment who has reached the maximum duration

of uninterrupted service under consecutive temporary appointments, as defined in Rule 420.4. Eligible staff members who do not wish to be considered for reappointment shall also give that period of notice of their intention.

- 1040.2 When a fixed-term or temporary appointment is due to expire during a period of maternity leave, paternity leave or adoption leave, the appointment may be extended for a period determined, and under conditions established, by the Director-General.

1083. NOTICE OF TERMINATION

Notice of termination under Staff Rules 1030, 1045, 1050, 1060, 1070 and 1080 may be served during periods of maternity leave, paternity leave or adoption leave. The effective date of separation shall be either the expiry date of the leave, or the end of the notice period under the relevant Rule, whichever is later.

1090. EFFECTIVE DATE OF TERMINATION

Subject to Rule 1083 on notice of termination during maternity leave, paternity leave and adoption leave, the effective date of termination shall be as follows:

- 1090.1 For staff locally recruited and those to whom Rules 1010.2 and 1010.3 apply, the last day of duty;
- 1090.2 For all other staff, that day on which it is calculated that the staff member, by departing promptly after completion of his duties, is able to reach his recognized place of residence by a route and means of transport designated by the Organization.
-

Attachment Appendix 1 to the Staff Rules

¹Salary scale for staff in the professional and higher categories; annual gross base salaries and net equivalents after application of staff assessment (in US dollars)
(effective 1 January 2007)

Level	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	XIII	XIV	XV
D-2															
Gross	138 549	141 494	144 443	147 391	150 354	153 437	*								
Net D	102 713	104 716	106 721	108 726	110 730	112 734	*								
Net S	94 360	96 052	97 737	99 417	101 092	102 760	*								
P-6/D-1															
Gross	126 565	129 153	131 738	134 326	136 915	139 501	142 090	144 678	147 265	*					
Net D	94 564	96 324	98 082	99 842	101 602	103 361	105 121	106 881	108 640	*					
Net S	87 407	88 937	90 462	91 985	93 504	95 020	96 531	98 040	99 544	*					
P-5															
Gross	104 600	106 803	109 004	111 204	113 407	115 607	117 810	120 012	122 213	124 415	126 615	128 818	131 019		
Net D	79 628	81 126	82 623	84 119	85 617	87 113	88 611	90 108	91 605	93 102	94 598	96 096	97 593		
Net S	73 975	75 305	76 631	77 957	79 280	80 599	81 918	83 234	84 547	85 858	87 167	88 474	89 779	*	*
P-4															
Gross	85 974	87 979	89 986	91 992	93 999	96 006	98 013	100 019	102 144	104 266	106 391	108 515	110 640	112 765	114 890
Net D	66 401	67 845	69 290	70 734	72 179	73 624	75 069	76 513	77 958	79 401	80 846	82 290	83 735	85 180	86 625
Net S	61 834	63 150	64 464	65 776	67 087	68 396	69 705	71 012	72 317	73 623	74 925	76 227	77 528	78 828	80 127
P-3															
Gross	70 222	72 079	73 939	75 793	77 653	79 508	81 364	83 224	85 082	86 938	88 797	90 651	92 511	94 367	96 224
Net D	55 060	56 397	57 736	59 071	60 410	61 746	63 082	64 421	65 759	67 095	68 434	69 769	71 108	72 444	73 781
Net S	51 395	52 625	53 857	55 085	56 317	57 545	58 775	60 005	61 234	62 464	63 689	64 916	66 141	67 366	68 592
P-2															
Gross	57 153	58 815	60 476	62 138	63 799	65 458	67 121	68 779	70 442	72 106	73 764	75 428			
Net D	45 650	46 847	48 043	49 239	50 435	51 630	52 827	54 021	55 218	56 416	57 610	58 808			
Net S	42 818	43 904	44 986	46 070	47 153	48 238	49 340	50 438	51 542	52 642	53 741	54 844			
P-1															
Gross	44 614	46 035	47 452	48 873	50 326	51 922	53 521	55 118	56 711	58 308					
Net D	36 137	37 288	38 436	39 587	40 735	41 884	43 035	44 185	45 332	46 482					
Net S	34 089	35 148	36 207	37 267	38 325	39 383	40 443	41 489	42 531	43 572					

¹

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

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

Appendix 2 to the Staff Rules

EDUCATION GRANT ENTITLEMENTS APPLICABLE IN CASES WHERE EDUCATIONAL EXPENSES ARE INCURRED IN SPECIFIED CURRENCIES AND COUNTRIES

(effective school year in progress 1 January 2007)

<i>Country/ currency area</i>	(1) Maximum admissible educational expenses and maximum grant for disabled children	(2) Maximum education grant	(3) Flat rate when boarding not provided	(4) Additional flat rate for boarding (for staff serving at designated duty stations)	(5) Maximum grant for staff members serving at designated duty stations	(6) Maximum admissible educational expenses for attendance (only when flat rate for boarding is paid)
Part A						
Euro						
Austria	15 198	11 399	3 564	5 346	16 745	10 447
Belgium	14 446	10 835	3 366	5 049	15 884	9 959
Finland	9 082	6 812	2 543	3 815	10 627	5 692
France*	10 263	7 697	2 921	4 381	12 078	6 368
Germany	18 993	14 245	4 090	6 134	20 379	13 540
Ireland	17 045	12 784	2 945	4 417	17 201	13 119
Italy	17 215	12 911	2 965	4 447	17 358	13 261
Luxembourg	12 898	9 673	3 147	4 720	14 393	8 701
Monaco	9 330	6 997	2 672	4 008	11 005	5 767
Netherlands	15 440	11 580	3 814	5 721	17 301	10 355
Spain	13 762	10 322	2 992	4 488	14 810	9 773
Denmark (krone)	108 147	81 110	24 715	37 072	118 182	75 193
Japan (yen)	2 324 131	1 743 098	534 345	801 517	2 544 615	161 167
Norway (deleted see USD outside USA)	-	-	-	-	-	-
Sweden (krona)	141 026	105 770	23 490	35 235	141 005	109 707
Switzerland (Swiss franc)	26 868	20 151	5 331	7 997	28 148	19 760
United Kingdom of Great Britain and Northern Ireland (pound sterling)	18 285	13 714	3 326	4 989	18 703	13 851
Part B						
United States dollar (outside the United States of America)**	18 048	13 536	3 490	5 235	18 771	13 395
Part C						
United States dollar (in the United States) ¹	34 598	25 949	5 406	8 109	34 058	27 391

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

1. American School of Paris
2. American University of Paris
3. British School of Paris
4. European Management School of Lyon
5. International School of Paris
6. Marymount School of Paris

** includes Norway, which will no longer be tracked as a separate zone

¹ Also applies, as a special measure, for China, Indonesia, and the Russian Federation.

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

Attendance at an educational institution outside the duty station

- (i) Where the educational institution provides board, the amount shall be 75% of the admissible costs of attendance and the costs of board up to the maximum indicated in column (1), with a maximum grant indicated in column (2) per year.
- (ii) Where the educational institution does not provide board, the amount shall be a flat sum as indicated in column (3), plus 75% of the admissible costs of attendance up to a maximum grant as indicated in column (2) per year.

Attendance at an educational institution at the duty station

- (iii) The amount shall be 75% of the admissible costs of attendance up to the maximum indicated in column (1), with a maximum grant as indicated in column (2) per year.
- (iv) Where the grant is payable for the cost of boarding for attendance at an educational institution in the country of the official station but beyond commuting distance from the official station, and when no suitable education facility exists in that area, the amount of the grant shall be calculated at the same rates as specified in (i) or (ii) above.

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

- (v) Where the educational institution provides board, the amount shall be:
 - a. 100% of the costs of board up to the maximum indicated in column (4); and
 - b. 75% of the admissible costs of attendance and of any part of the costs of board in excess of the amount indicated in column (4), with a maximum reimbursable amount as indicated in column (5).
 - (vi) Where the educational institution does not provide board, the amount shall be:
 - a. A flat sum for board as indicated in column (4); and
 - b. 75% of the admissible costs of attendance, with a maximum reimbursable amount as indicated in column (5).
-

ANNEX 2

Scale of assessments 2008–2009

Report by the Director-General

[EB120/20 – 15 January 2007]

1. The Fifty-eighth World Health Assembly adopted a scale of assessments for 2006–2007 reflecting the application to WHO of the latest available United Nations scale.¹
2. The latest available United Nations scale is the scale of assessments adopted in December 2006.² It is therefore proposed that this United Nations scale should be used by WHO for the financial period 2008–2009.

ACTION BY THE EXECUTIVE BOARD

3. [The Board recommended that the Sixtieth World Health Assembly should adopt the scale of assessments for 2008–2009 as set out in resolution EB120.R18.]

¹ Resolution WHA58.19.

² United Nations General Assembly resolution 61/237, as approved by the General Assembly on 21 December 2006.

ANNEX 3

Director-General and Deputy Director-General of the World Health Organization: review of matters arising from the special and 118th sessions of the Executive Board¹

Report by the Secretariat

[EB120/30 – 28 December 2006]

1. At its special session (23 May 2006), and at its 118th session during consideration of the agenda items on acceleration of the procedure to elect the next Director-General of the World Health Organization and on the Deputy Director-General, the Board reviewed and discussed several aspects of the situation arising out of the death of the late Director-General, Dr Jong-wook Lee.² It focused in particular on the modalities by which a Deputy Director-General was appointed and on the imperfect alignment of the Rules of Procedure of the World Health Assembly and of the Executive Board in case of a vacancy in the post of Director-General. Some members also raised the question of regional rotation of the post of Director-General.

2. As requested, the present report deals with relevant aspects of the foregoing issues, together with some practical aspects of the procedure for the nomination of a person to the post of Director-General which would warrant clarification, based on the experience gained during the process just concluded.

RULES OF PROCEDURE OF THE WORLD HEALTH ASSEMBLY AND THE EXECUTIVE BOARD

3. At both its special session and 118th session, the Board made comments to the effect that there was an inconsistency between Rule 109 of the Rules of Procedure of the World Health Assembly and Rule 52 of the Rules of Procedure of the Executive Board in case of a sudden vacancy in the post of Director-General. In particular, Rule 109 prescribes that, whenever the office of Director-General is vacant, the Board shall, at its next meeting, make a nomination which shall be submitted to the next session of the Health Assembly. In contrast, Rule 52 of the Rules of Procedure of the Executive Board lays out a structured process beginning at least six months before the opening of a session of the Board at which a Director-General is to be nominated. In case of a sudden vacancy in the post of Director-General, it might be hard to reconcile the requirements of those two rules if they are

¹ See resolution EB120.R19.

² See document EBSS-EB118/2006/REC/1, summary record of the special session and summary records of the first, second, third and fourth meetings of the 118th session.

interpreted literally. On the other hand, those provisions were drafted at different times and should be interpreted flexibly in particular circumstances, having regard to their fundamental purpose, namely, to ensure a swift yet orderly and thorough process of nomination of a new Director-General. The Board at its 118th session therefore considered that it was within its authority under its Rules of Procedure to defer nomination of the next Director-General to its 119th session.

4. Thus the way in which the two rules can be reconciled might be sufficient to guide the Board in case of a future sudden vacancy in the post of Director-General. Alternatively, consideration could be given to amending the Rules of Procedure of the World Health Assembly and of the Executive Board in order to clarify the situation. The amendment could provide that the Board would make a nomination as soon as possible, rather than specifically at its next meeting.

PROCEDURE FOR NOMINATION OF THE DIRECTOR-GENERAL

5. The procedure for nomination of the Director-General by the Board is based on Rule 52 of the Rules of Procedure of the Executive Board, and decision EB100(7) which contains detailed provisions for implementing certain aspects of Rule 52. Resolution EB97.R10 sets forth the criteria that should be fulfilled by the candidate nominated by the Board.

6. Even though the overall process, which has been followed on three occasions (1998, 2003 and 2006), has been implemented smoothly, the legal basis of some aspects is not entirely clear and could raise uncertainties or cause difficulties for the Chairman of the Executive Board or the Secretariat, as outlined below.

7. One of the criteria that the candidate nominated by the Executive Board should fulfill is “the good physical condition required of all staff members of the Organization”. The Board, however, did not clarify the way in which the matter should be handled. Consequently, the Secretariat developed the following procedure to assure that this criterion is met. The Secretariat invites the persons who have been proposed for the post of Director-General to undergo a medical examination and to have a completed WHO medical examination form brought to the attention of the Director, Health and Medical Services at headquarters. The Director, Health and Medical Services, in turn reports to the Chairman of the Board whether the candidates appear to enjoy the good physical condition required of all staff members of WHO, and the Chairman informs the Board accordingly.

8. All candidates in the last three nomination processes have complied with the request to submit a medical examination form, and all have been found to enjoy the required physical condition. The process as described has been acceptable to candidates and Board members. Nonetheless, lack of definition by the Board of a specific procedure to assure compliance with the aforementioned criterion leaves its legal force unclear, for example, in the case of a candidate who refuses to produce a medical examination form, and could raise issues of privacy if specific information about the health status of a candidate were to be reported to the Board.

9. Paragraph (1) of decision EB100(7) states that “there should be a guideline of two to three pages for each candidate’s curriculum vitae;...”. The Chairmen of the Board, on the occasion of the last three nominations, have tackled the question of material that substantially exceeded three pages by extracting essential parts of the documentation received so as to reduce it to the limit envisaged by the guideline. The practical difficulty of this process has led to some difference in length in the documentation distributed to the Board, although there has been no criticism from either members or candidates. Notwithstanding, the legal force of “a guideline” is unclear, which could expose the Chairman of the Board to challenges should a candidate, or the Member State that proposed him or

her, object to the reduction in the length of the material submitted. It would be preferable for the Board to specify that the limit of three pages is a requirement that can be enforced by the Chairman of the Board. Moreover, in view of the wide variations in the format of curricula vitae (e.g. font size, line spacing, page layout), the Board may wish to consider moving from a limit based on a number of pages to one based on the total number of words, for example, 2000 words.

10. Rule 52 provides that the proposals received from Member States, curricula vitae and supporting information should be translated into all official languages, duplicated and dispatched to all Member States one month before the opening of the Board's session. The Rule does not clarify what information the Secretariat may make public. Because of the high level of interest in the election of a Director-General of WHO, the Secretariat is subject to pressure from the media to release information. Lack of a clear legal basis as to what it may do with information concerning the candidates places the Secretariat in a difficult position. For the election just concluded it released only the names of the candidates. Given the ease with which such information may be retrieved and circulated through electronic media, it could be argued that the transparency and legitimacy of the process would benefit from its public disclosure. The Board may wish to consider whether, in addition to the names of candidates, the Secretariat may post on WHO's web site the curricula vitae and other supporting information as dispatched to Member States, and contact information, unless the candidate concerned or the Member State that proposed him or her stipulates otherwise,

DEPUTY DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION

History

11. The position of Deputy Director-General of the World Health Organization has been filled for approximately 42 years and, on an *ad interim* basis, for approximately two years in the 59 years of the Organization's existence.¹

12. Specifically, the position of Deputy Director-General was occupied from 21 August 1950 to 1 August 1992, with one three-week interruption. During this period, the position was filled by three staff members, namely: Dr Pierre Dorolle from 21 August 1950 to 31 October 1973; Dr Thomas Lambo, from 1 November 1973 until 1 July 1988 (with the exception of a short period in 1974, when the position was filled by Dr Dorolle); and from 21 July 1988 to 1 August 1992 by Dr Mohammed Abdelmoumène. In addition, from 1 June 1996 to 21 July 1998, the position of Deputy Director-General was filled by two Assistant Directors-General, who were appointed Deputy Director-General on an *ad interim* basis from 1 June 1996 to 1 May 1997 and from 1 May 1997 to 21 July 1998, respectively.

13. Most recently, Dr Anders Nordström was appointed Deputy Director-General by the late Director-General Dr Lee, and began exercising those functions immediately after the death of Dr Lee on 22 May 2006. The Board reviewed the situation at its special session and appointed Dr Nordström to serve as Acting Director-General.²

¹ See document EB118/19.

² Decision EBSS(1).

Conditions of employment

14. The conditions of employment of the Deputy Director-General are determined in accordance with the Staff Regulations and Staff Rules of WHO. According to Staff Regulation 3.1, “The salaries for the Deputy Director-General, Assistant Directors-General and Regional Directors shall be determined by the World Health Assembly on the recommendation of the Director-General and with the advice of the Executive Board.”.

15. The posts of Director-General, Deputy Director-General, Regional Directors and Assistant Directors-General are all ungraded posts. Within this ungraded category, there are three levels: Regional Directors and Assistant Directors-General are at the first level, the Deputy Director-General is at the second level, and the Director-General is at the third level.

16. The level of remuneration for the Deputy Director-General is equivalent to that of an Under Secretary-General in the United Nations. The salary for the position of Deputy Director-General at WHO was last set in 1998. The Board at its current session will consider the salary to be recommended to the Sixtieth World Health Assembly, namely, a gross level of US\$ 185 874 with a corresponding net salary of US\$ 133 818 (dependency rate) or US\$ 120 429 (single rate)¹.

17. WHO’s staffing tables have been updated to show the position of Deputy Director-General, whether the position is occupied or not.

Appointment of the Deputy Director-General

18. The Deputy Director-General is an official appointed by the respective Director-General in the exercise of his or her authority under WHO’s Constitution and Staff Regulations.

19. Specifically, Article 31 of the WHO’s Constitution states that the Director-General is “... the chief technical and administrative officer of the Organization.”. Article 35 of the WHO Constitution states, “The Director-General shall appoint the staff of the Secretariat in accordance with staff regulations established by the Health Assembly.” Staff Regulation 4.1 states, “The Director-General shall appoint staff members as required”, and paragraph 4.5 of the same Regulation refers specifically to the appointment of the Deputy Director-General.

Duties of the Deputy Director-General

20. With the intention of appointing a Deputy Director-General, the Director-General elect foresees certain general parameters for the post. The Deputy Director-General would, as assigned, undertake special initiatives of high-priority and carry out specific, high-level, technical and administrative functions. He or she would play an important role in assisting the Director-General in leading and managing the programmes and operations of WHO. The Deputy Director-General would support the Director-General in ensuring coherence of activities and programmes that cross functional sectors. He or she would also assist the Director-General in efforts to heighten public awareness of WHO’s priority activities. The incumbent would also perform the functions of Director-General should the Director-General be unable to perform the functions of the office or in case of a vacancy in the office, subject to any relevant decision by the Executive Board.

¹ See document EB120/29.

21. It is not expected that the Deputy Director-General would act on behalf of the Director-General during her absence on duty travel or leave, or replace the Director-General in her primary role of collaboration with Regional Directors in pursuing WHO's work globally.
22. The Director-General elect has confirmed that the appointment of a Deputy Director-General would be announced publicly, without delay.¹

GEOGRAPHICAL ROTATION OF THE POST OF DIRECTOR-GENERAL

23. Neither WHO's Constitution nor Rules of Procedure of the World Health Assembly provide for the rotation of the post of Director-General among the six regions of WHO. Article 31 of the Constitution states only "The Director-General shall be appointed by the Health Assembly on the nomination of the Board on such terms as the Health Assembly may determine." Rule 108 of the Rules of Procedure of the World Health Assembly is congruent with Article 31.

24. There have been seven Directors-General of WHO:

Dr Brock Chisholm (Canada), 1948–1953

Dr Marcolino Gomes Candau (Brazil), 1953–1973

Dr Halfdan Mahler (Denmark), 1973–1988

Dr Hiroshi Nakajima (Japan), 1988–1998

Dr Gro Harlem Brundtland (Norway), 1998–2003

Dr Jong-wook Lee (Republic of Korea), 2003–2006

Dr Margaret Chan (China), Director-General elect assuming office on 4 January 2007.

25. A number of other organizations of the United Nations system, and related organizations were consulted about their statutory provisions and practices.² All those that replied reported that neither their constitution nor rules contained a requirement for geographical rotation for the post of executive head. Most organizations have no established practice in this regard, and the pattern of elections of the executive head shows that, although consideration of regional rotation carried some weight at a political level, it did not impinge directly on selection.

26. From a legal view point, it should be noted that Article 35 of WHO's Constitution states,

The paramount consideration in the employment of the staff shall be to assure that the efficiency, integrity and internationally representative character of the Secretariat shall be maintained at the highest level. Due regard shall be paid also to the importance of recruiting the staff on as wide a geographical basis as possible.

Although that provision is largely addressed to the Director-General, who has the constitutional authority to appoint the staff of the Organization, Article 35 makes it clear that geographical

¹ The Director-General appointed the Deputy Director-General on 10 January 2007.

² The following organizations responded to the request for information: United Nations, WMO, UNESCO, ITU, Organisation for the Prohibition of Chemical Weapons, ICAO, FAO, International Organization for Migration, WIPO, ILO, IMO and IMF.

representation, albeit an important consideration, is secondary to the paramount criterion of the highest standard of efficiency and integrity. The Executive Board may wish to keep this consideration in mind when discussing the issue of geographical rotation of the post of Director-General.

ACTION BY THE EXECUTIVE BOARD

27. [This paragraph contained a draft resolution which was adopted at the thirteenth meeting as resolution EB120.R19.]

ANNEX 4

Nongovernmental organizations admitted into, or maintained in official relations with WHO by virtue of, respectively, EB120.R20 and decision EB120(2)

[EB120/41, Annex – 27 January 2007]

African Medical and Research Foundation
Aga Khan Foundation
CMC – Churches' Action for Health
Commonwealth Medical Association
Commonwealth Pharmaceutical Association
Consumers International¹
Corporate Accountability International
Council for International Organizations of Medical Sciences
Council on Health Research for Development
EuroSafe - European Association for Injury Prevention and Safety Promotion
Global Forum for Health Research
Global Health Council
International Alliance of Patients' Organizations
International Association for Dental Research²
International Association of Biologists Technicians
International Association of Cancer Registries
International Association of Hydatid Disease²
International Association of Logopedics and Phoniatrics
International Association of Medical Regulatory Authorities
International Catholic Committee of Nurses and Medico-social Assistants
International College of Surgeons
International Commission on Radiological Protection
International Confederation of Midwives
International Conference of Deans of French-Language Faculties of Medicine
International Council for Standardization in Haematology
International Council of Nurses
International Epidemiological Association
International Federation for Housing and Planning
International Federation for Medical and Biological Engineering
International Federation of Biomedical Laboratory Science
International Federation of Clinical Chemistry and Laboratory Medicine
International Federation of Health Records Organizations
International Federation of Hospital Engineering
International Federation of Medical Students Associations

¹ Previously known as International Organization of Consumers Unions (Consumers International).

² Activities concern the period 2003–2005.

International Federation of Pharmaceutical Manufacturers and Associations¹
 International Federation of Surgical Colleges
 International Hospital Federation
 International League of Dermatological Societies
 International Medical Informatics Association
 International Medical Parliamentarians Organization
 International Organization for Standardization
 International Pharmaceutical Federation
 International Pharmaceutical Students' Federation
 International Society for Biomedical Research on Alcoholism
 International Society for Burn Injuries
 International Society for Environmental Epidemiology
 International Society for Preventive Oncology
 International Society of Blood Transfusion
 International Society of Doctors for the Environment²
 International Society of Hematology
 International Society of Nurses in Cancer Care
 International Society of Orthopaedic Surgery and Traumatology
 International Society of Radiographers and Radiological Technologists
 International Society of Radiology
 International Union against Cancer²
 International Union against Tuberculosis and Lung Disease²
 International Union for Conservation of Nature and Natural Resources²
 International Union of Architects
 International Union of Basic and Clinical Pharmacology³
 International Union of Microbiological Societies
 Medicus Mundi International–International Organisation for Cooperation in Health Care
 OXFAM
 The International Federation of Anti-Leprosy Associations
 The International Society for Quality in Health Care Incorporated
 The International Society on Thrombosis and Haemostasis, Inc.
 The Network: Towards Unity For Health
 The Save the Children Fund
 The World Federation of Acupuncture–Moxibustion Societies
 World Association of Societies of Pathology and Laboratory Medicine
 World Association for Sexual Health
 World Federation for Medical Education
 World Federation for Ultrasound in Medicine and Biology
 World Federation of Chiropractic
 World Federation of Neurosurgical Societies⁴
 World Federation of Nuclear Medicine and Biology
 World Federation of Public Health Associations
 World Federation of Societies of Anaesthesiologists
 World Medical Association

¹ Previously known as International Federation of Pharmaceutical Manufacturers Association.

² Activities concern the period 2003–2005.

³ Previously known as International Union of Pharmacology.

⁴ Activities concern the period 2002–2004.

World Organization of Family Doctors
World Organization of the Scout Movement
World Plumbing Council
World Self-Medication Industry
World Veterinary Association
World Vision International

ANNEX 5

Confirmation of approval by the United Nations General Assembly of the International Civil Service Commission's general framework, including implementation and cost of amendments to the Staff Rules

Postponement of effective date of amendments to the Staff Rules

Report by the Secretariat

[EB120/26 – 11 January 2007]

INTRODUCTION

1. The Executive Board at its 118th session in May 2006 considered the Secretariat's report on a new framework of contractual arrangements, and adopted resolution EB118.R5, which confirmed the related amendments to the Staff Rules.¹
2. The confirmation by the Executive Board was subject to the endorsement by the United Nations General Assembly of the general framework recommended by the International Civil Service Commission. In addition, the Executive Board requested the Director-General to submit to the Board at its session in January 2007 a full report on implementation and cost of the amendments to the Staff Rules through the Programme, Budget and Administration Committee.
3. The present report reviews the implementation measures and cost implications of contract reform. It also invites the Executive Board to confirm the amendments to the Staff Rules related to contract reform, with a new effective date of 1 July 2007.

IMPLEMENTATION MEASURES

4. Since the 118th session of the Executive Board, the Secretariat has been engaged at headquarters and regional levels in elaborating measures for implementing the contract reform policies.

¹ Document EBSS-EB118/2006/REC/1, summary record of the fifth meeting, section 2.

5. Several policy documents have been prepared on types of appointments, conversion into continuing appointment, and conditions of service of temporary staff (including temporary staff on appointments of 60 days or less). These documents and related implementation and transition measures for moving to the new types of temporary appointments were the subject of several videoconferences involving staff representatives and members of the administration. They were also discussed at the annual meeting of the Global Staff/Management Council, which took place from 30 October to 3 November 2006 in Washington, DC. Following a review of the recommendations of the Council, the Acting Director-General approved the measures for implementing the contract reform policies. In a parallel process, the Secretariat has identified the amendments that need to be made to the policies and procedures set out in the WHO e-Guide, which is accessible to all staff.

6. The modifications and adjustments to the current payroll systems needed before launch of the global management system on 1 January 2008 are also being identified. Meanwhile, the specifications of the global management system have been designed to reflect the new contractual arrangements, related Staff Rules and policy implementation measures.

7. Managers and staff members have been kept abreast of developments. In preparation for the entry into force of the new contractual arrangements, policy guidelines have been issued on the management of temporary functions, including the application of the maximum duration of service and on the management of fixed-term and temporary contracts and other contractual arrangements, such as those for short-term consultants.

8. In addition, briefing sessions have been held with staff and managers at headquarters and regional levels and information has been shared on developments relating to contract reform, implementation measures and related policy guidelines.

COST IMPLICATIONS

9. The cost implications of contract reform were provided to the Executive Board at its 118th session.¹ At that time, the cost was set at US\$ 22.8 million. With the new implementation date of 1 July 2007, total costs will be significantly lower, at US\$ 8.6 million.² These costs will be absorbed internally at headquarters and regional levels by making appropriate adjustments to workplans.

THE EFFECTIVE DATE OF AMENDMENTS TO THE STAFF RULES RELATED TO CONTRACT REFORM

10. At its 118th session, the Executive Board confirmed the decision of the Director-General to amend the Staff Rules related to contract reform, with effect from 1 January 2007, subject to the endorsement by the United Nations General Assembly of the general framework recommended by the International Civil Service Commission. The Board is now asked to confirm the amendments, other than those concerned with mobility and hardship allowance and assignment

¹ Document EB118/11 Add.1.

² See document EB120/26 Add.1.

grant,¹ with respect to staff members holding career service/service and fixed-term appointments, with a new effective date of 1 July 2007.

11. An implementation date of 1 July 2007 for the amended Staff Rules will reduce the financial costs to the Organization and facilitate their absorption into the current budget; it will also provide the additional time needed in order to put in place the necessary policies and procedure and make the appropriate adjustments to systems and administrative processes.

12. In so far as developments at the level of the United Nations General Assembly are concerned, there is growing concern that the discussion at the United Nations General Assembly may be dominated by consideration of human resources management reform efforts that are particular to the United Nations Secretariat and unrelated to the needs and requirements of specialized agencies such as WHO. There is also concern that the review of this subject by the United Nations General Assembly may ultimately be deferred to that body's sixty-second session in December 2007.

13. The International Civil Service Commission's general framework has been endorsed by all the organizations of the United Nations common system, their staff representatives and the members of the Commission. The goals and objectives as well as main features of the new framework of contractual arrangements were set out in detail in the report submitted to the Executive Board at its 118th session.² It should be emphasized that improved and more responsive contractual arrangements and conditions of service are essential for the successful delivery of WHO's results-based programmes. The new framework of contractual arrangements will provide WHO with a competitive edge, reinforcing the Organization's capacity to implement internal reform strategies and initiatives for delivering programmes more effectively and efficiently.

14. Based on the aforementioned consideration, it is requested that the confirmation of the Board of the amendments to the Staff Rules on contract reform, with a new effective date of 1 July 2007, should be given this time around without reference to the debate in the United Nations General Assembly.

15. If the United Nations General Assembly does endorse the International Civil Service Commission's general framework in December 2006, WHO, unlike other organizations, will have already ensured the integration of contract reform into its strategic reform efforts at the programme and managerial levels.

ACTION BY THE EXECUTIVE BOARD

16. [This paragraph contained a draft decision which was adopted at the twelfth meeting as decision EB120(1).]

¹ The International Civil Service Commission has recommended to the United Nations General Assembly that the proposals relating to mobility and hardship allowance and assignment grant should come into effect on 1 January 2007. As these proposals entail savings in costs, it is expected that the United Nations General Assembly will endorse that recommendation.

² Document EB118/11.

ANNEX 6

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

1. Resolution EB120.R1 Poliomyelitis: mechanism for management of potential risks to eradication	
2. Linkage to programme budget	
Area of work	Expected result
Immunization and vaccine development	7. Effective coordination and support provided to interrupt circulation of any reintroduced poliovirus, to achieve certification of global poliomyelitis eradication, to develop products for the cessation of oral poliovirus vaccine, and to integrate the Global Polio Eradication Initiative into the mainstream of health delivery systems.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The resolution has links with the first two indicators for the expected result.	
3. Financial implications	
(a) Total estimated cost for implementation over the “life-cycle” of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)	
A maximum of US\$ 3 180 000 (including staff, documentation costs, meetings of the Review Committee of the International Health Regulations (2005) and, if needed, intergovernmental meetings).	
(b) Estimated cost for the biennium 2006-2007 (estimated to the nearest US\$ 10 000, including staff and activities)	
US\$ 795 000 (including two staff and documentation costs for one year, as well as two meetings of the Review Committee of the International Health Regulations (2005)).	
(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities?	
US\$ 545 000, representing staff costs and one meeting of the Review Committee.	
4. Administrative implications	
(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions where relevant)	
This will involve work at headquarters and all regional offices.	
(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile)	
One full-time staff member in the professional category; one full-time staff member in the general service category.	
(c) Time frames (indicate broad time frames for implementation and evaluation)	
Approximately 48 months.	

1. Resolution EB120.R3 Tuberculosis control: progress and long-term planning

2. Linkage to programme budget

Area of work

Tuberculosis

Expected results

1. A global plan for DOTS expansion, geared to reaching Millennium Development Goal 6, implemented.
2. Implementation of long-term national plans for DOTS expansion and sustained tuberculosis control supported through functional national partnerships.
3. Global TB Drug Facility and the Green Light Committee maintained and expanded access to treatment and cure supported.
4. Political commitment sustained and mobilization of adequate resources ensured through nurturing of the Stop TB partnership and effective communication of the concept, strategy and progress of the Global Plan to Stop TB.
5. Surveillance and evaluation systems at national, regional and global levels maintained and expanded to monitor progress towards targets, resource allocations for tuberculosis control, and impact of control efforts.
6. Adequate guidance and support provided to countries to tackle multidrug-resistant tuberculosis and to improve tuberculosis-control strategies in countries with high HIV prevalence.
7. Better tuberculosis case-detection and cure rates promoted and supported through all public and private providers and community-based services, and integrated respiratory care implemented at primary level.

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

The resolution, which builds on the Stop TB Partnership's Global Plan to Stop TB 2006–2015 and progress achieved towards the targets set in resolution WHA58.14 on Sustainable financing for tuberculosis prevention and control, provides the framework for achieving the tuberculosis control-related expected results and targets outlined in strategic objective (2) in the Draft Medium-term strategic plan, 2008–2013.

3. Financial implications

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

In order to fulfil WHO's leadership role in supporting implementation of the Global Plan to Stop TB 2006–2015, an estimated US\$ 1800 million will be required over the 10-year period (including the 2006–2007 biennium). These costs are in line with the current biennium workplan, increase in activities foreseen under the Global Plan and the strategic objectives in the Draft Medium-term strategic plan 2008–2013.

(b) Estimated cost for the biennium 2006–2007 (estimated to the nearest US\$ 10 000, including staff and activities)

US\$ 260 million: this includes the revised budget of US\$ 235 million for the tuberculosis area of work, and an additional US\$ 25 million required for WHO's role in laboratory strengthening, tuberculosis-impact assessment, and global support to national responses to the emergence of extensively drug-resistant tuberculosis in 2007.

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

All actions to be pursued are included under the Programme Budget 2006–2007, except the additional actions now required in 2007 in response to extensively drug-resistant tuberculosis.

4. Administrative implications

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

The response includes actions by all levels of the Organization, including all regions and most country offices. All WHO core functions will be involved for each level of the Organization.

(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile)

During the remainder of this biennium, no absolute growth is expected in headquarters staffing. In the African Region, additional staff will be required in 2007 to cope with extensively drug-resistant tuberculosis and implement the associated increase in tuberculosis and tuberculosis/HIV interventions, including urgent support for laboratory strengthening (e.g. two full-time equivalents), and country-based medical officers and national professional officers for technical cooperation, capacity building and surveillance (e.g. at least 15 full-time equivalents). From 2008 to 2015, some growth in staff numbers in all regions is planned, especially to strengthen technical cooperation in more extensive impact evaluation and tuberculosis/HIV and multidrug-resistant tuberculosis interventions. Full-time equivalent estimates are being developed under the Draft Medium-term strategic plan, 2008–2013.

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

2006–2015. Evaluation of progress made on 2015 targets will continue to the end of 2017 at least.

1. Resolution EB120.R4 Health systems: emergency-care systems	
2. Linkage to programme budget	
Area of work	Expected result
Violence, injuries and disabilities	3. Guidance and effective support provided for strengthening of health-care systems for persons affected by violence and injuries.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The relevant expected result is health-care systems strengthening to meet the needs of persons affected by violence and injuries, and the resolution provides the framework. It indicates actions that can be taken by Member States and the Secretariat, emphasizing the low cost of such system strengthening and the cost-effective measures involved, particularly in low- and middle-income settings.	
3. Financial implications	
(a) Total estimated cost for implementation over the “life-cycle” of the resolution (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 7 000 000 over 15 years	
(b) Estimated cost for the biennium 2006-2007 (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 300 000	
(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? US\$ 300 000	
4. Administrative implications	
(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions where relevant)	
Headquarters and all regions.	
(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile)	
No additional staffing requirements foreseen.	
(c) Time frames (indicate broad time frames for implementation and evaluation)	
2007–2022.	

1. Resolution EB120.R5 Oral health: action plan for promotion and integrated disease prevention	
2. Linkage to programme budget	
Area of work	Expected results
Health promotion	1. Increased guidance for integrating health promotion into health plans, including healthy diet, physical activity, ageing and oral health.
Surveillance, prevention and management of chronic, noncommunicable diseases	1. Support provided to countries for framing policies and strategies for prevention and management of chronic, noncommunicable diseases at national level, including integration of primary and secondary prevention into health systems. 5. Improved quality, availability, comparability and dissemination of data on chronic, noncommunicable diseases and their major modifiable risk factors.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
3. Financial implications	
(a) Total estimated cost for implementation over the “life-cycle” of the resolution (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 3 230 000 between 2008 and 2013	
(b) Estimated cost for the biennium 2006-2007 (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 1 040 000	
(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? US\$ 1 040 000	
4. Administrative implications	
(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions where relevant)	
Implementation of the resolution will require participation of all levels of the Organization, with activities focused on low- and middle-income countries. There will be a particular emphasis on the 23 countries that account for 80% of the burden of chronic, noncommunicable diseases in low- and middle-income countries.	
(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile)	
No additional staffing requirements are foreseen.	
(c) Time frames (indicate broad time frames for implementation and evaluation)	
Implementation will take place from 2007 to 2013.	

1. Resolution EB120.R6 Integrating gender analysis and actions into the work of WHO: draft strategy	
2. Linkage to programme budget	
Area of work	Expected result
Gender, women and health	2. Evidence translated into standards and strategies for integrating gender into technical programmes and policies in the health sector.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
<p>The resolution is consistent with the expected result. Approval of the strategy by the Health Assembly was noted in the Programme budget 2006–2007 as the target for the above-mentioned expected result. Formulation of the strategy constituted the baseline, and progress in implementing the strategy constituted the main indicator of achievement.</p>	
3. Financial implications	
(a) Total estimated cost for implementation over the “life-cycle” of the resolution (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 104 483 600	
(b) Estimated cost for the biennium 2006-2007 (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 8 850 000	
(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities?	
Approximately US\$ 5.2 million of the proposed expenditure for the remainder of the current biennium can be absorbed under existing programmed activities. Additional funding of US\$ 3 650 000 is therefore required.	
4. Administrative implications	
(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions where relevant)	
The strategy will be implemented at all levels of the Organization.	
(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile)	
From 2008, 20.7 staff are required in the professional category in headquarters; three staff are required in the professional category in the regional offices; and two national programme officers are needed in the European Region.	
(c) Time frames (indicate broad time frames for implementation and evaluation)	
The strategy will be implemented from 2007 to 2013. An evaluation is expected to be undertaken for 2012.	

1. Resolution EB120.R7 Avian and pandemic influenza: developments, response and follow-up, application of the International Health Regulations (2005), and best practice for sharing influenza viruses and sequence data	
2. Linkage to programme budget	
Area of work Epidemic alert and response	Expected result 2. Support provided to Member States for strengthening national communicable disease surveillance and response systems, including the capability for early detection, investigation of, and response to, epidemics, pandemics and emerging infectious disease threats.
<p align="center">(Briefly indicate the linkage with expected results, indicators, targets, baseline)</p> <p>The resolution is fully consistent with the expected results for the area of work and with the strategic objective in the draft medium-term strategic plan to reduce the health, social and economic burden of communicable diseases. It also supports the objectives of WHO's Global Pandemic Influenza Action Plan to Increase Vaccine Supply.</p>	
3. Financial implications	
<p>(a) Total estimated cost for implementation over the "life-cycle" of the resolution (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 2 780 000</p> <p>(b) Estimated cost for the biennium 2006-2007 (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 830 000</p> <p>(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? US\$ 300 000</p>	
4. Administrative implications	
<p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions where relevant) All levels of the Organization; national implementation specifically supported by regional and country offices, with international coordination at headquarters.</p> <p>(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile) No additional staffing expected at country level; the equivalent of four full-time staff with experience in virology and laboratory strengthening and a broad range of issues related to pandemic influenza vaccine, from production and logistics to communications and coordination, would be required for strengthening at regional level (25%) and global coordination (75%) for 2007–2008.</p>	
<p>(c) Time frames (indicate broad time frames for implementation and evaluation) Projects already under way in this biennium for laboratory strengthening, research coordination and facilitation of specimen shipment will be continued and accelerated during the biennium 2008–2009. Longer-term implementation will be linked to WHO's Global Pandemic Influenza Action Plan to Increase Vaccine Supply.</p>	

1. Resolution EB120.R8 Smallpox eradication: destruction of variola virus stocks	
2. Linkage to programme budget	
Area of work	Expected result
Epidemic alert and response	2. Support provided to Member States for strengthening national communicable disease surveillance and response systems, including the capability for early detection, investigation of and response to, epidemics, pandemics and emerging infectious disease threats.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
3. Financial implications	
(a) Total estimated cost for implementation over the “life-cycle” of the resolution (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 5.0 million.	
(b) Estimated cost for the biennium 2006-2007 (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 430 000, (US\$ 120 000 for committed activities, US\$ 65 000 for biosafety visits to the WHO Collaborating Centres for Smallpox, US\$ 10 000 for maintaining the vaccine stockpile, US\$ 230 000 for review/equivalent activity if requested (one full-time staff member in the professional category and one at 50% in the general service category).	
(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? None.	
4. Administrative implications	
(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions where relevant) All activities are to be coordinated at headquarters.	
(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile) One full-time medical officer with relevant experience and a 20% full-time equivalent logistician.	
(c) Estimated cost for biennium 2008–2009 (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 1.0 million.	
(d) Time frames (indicate broad time frames for implementation and evaluation) 10 years.	

1. Resolution EB120.R10 Confirmation of amendments to the Staff Rules	
2. Linkage to programme budget	
Area of work	Expected result
Human resources management in WHO	4. Conditions of service improved and staff-friendly policies implemented; WHO pay and benefits system brought into line with the United Nations field-oriented organizations' system.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The resolution will encourage more staff-friendly policies and better adherence to common system principles for management of human resources.	
3. Financial implications	
<p>(a) Total estimated cost for implementation over the "life-cycle" of the resolution (estimated to the nearest US\$ 10 000, including staff and activities) The cost of the proposals is difficult to estimate as the entitlements being amended are exercised in a limited fashion and only by staff whose circumstances correspond to those covered by the entitlement. As opposed to the cost of compensation allowances and benefits, the cost of staff-friendly entitlements is not of a recurrent nature as such entitlements apply only in the narrow range circumstances described in the document.</p> <p>(b) Estimated cost for the biennium 2006-2007 (estimated to the nearest US\$ 10 000, including staff and activities) The rationale mentioned under 3(a) above applies.</p> <p>(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? Any additional costs would be subsumed under existing programmed activities.</p>	
4. Administrative implications	
<p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions where relevant) Not applicable.</p> <p>(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile) No additional staffing requirements needed.</p> <p>(c) Time frames (indicate broad time frames for implementation and evaluation) As of promulgation of the amended Staff Rules.</p>	

1. Resolution EB120.R12 Rational use of medicines	
2. Linkage to programme budget	
Area of work	Expected result
Essential medicines	7. Awareness raising and guidance on cost-effective and sound use of medicines promoted, with a view to improving use of medicines by health professionals and consumers.
<p>(Briefly indicate the linkage with expected results, indicators, targets, baseline)</p> <p>The resolution is consistent with the expected result and will ensure that promotion of rational use of medicines is treated as a priority in all areas of WHO's work. Within this area of work it will enable Member States – as an essential part of providing adequate health care for their populations – to monitor medicines use and implementation of policies to promote rational use of medicines.</p> <p>The successful implementation of this resolution will assist in expanding the evidence base and strengthening provision of support and its coordination to Member States for promoting rational use of medicines. It will be measured through monitoring of medicines use and implementation of policies at country level. Additional work resulting from this resolution is consistent with work planned under strategic objective 12 in the Draft Medium-term strategic plan 2008–2013. In 2007 the additional work will be monitored by the indicator for measuring the percentage of prescriptions that are in accordance with national or institutional guidelines.</p>	
3. Financial implications	
<p>(a) Total estimated cost for implementation over the “life-cycle” of the resolution (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 30 million over six years.</p> <p>(b) Estimated cost for the biennium 2006-2007 (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 1.5 million from June to December 2007.</p> <p>(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? US\$ 500 000 from June to December 2007. Additional funding of US\$ 1 million is therefore required.</p>	
4. Administrative implications	
<p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions where relevant)</p> <p>Normative, technical and coordinating work will be performed at headquarters, while the majority of the planning and implementation work will be carried out at regional and country levels. Overall, 77% of the financial and human resources will be allocated to regions and countries.</p> <p>(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile)</p> <p>In order to establish a coordinated and integrated health-systems approach to promoting rational use of medicines, a global team will need to be established, comprising the following staff for each region: a regional adviser, a supporting technical officer and a secretary. At headquarters there will need to be a coordinating team comprising a medical officer, two technical officers and a secretary. An additional technical officer will be needed at headquarters to liaise with other programmes. Since almost no function can be subsumed under existing staff numbers, 23 additional staff will be needed for the posts mentioned above.</p> <p>(c) Time frames (indicate broad time frames for implementation and evaluation)</p> <p>Monitoring of medicines use and implementation of medicines policy has already been established, a series of training programmes have been organized and a number of small projects supported, in both the current and previous bienniums. The establishment of a global team would enable full-scale implementation of activities in the biennium 2008–2009.</p>	

1. Resolution EB120.R13 Better medicines for children	
2. Linkage to programme budget	
Area of work	Expected results
Essential medicines	<p>1. Implementation and monitoring of medicines policies based on the concept of essential medicines, monitoring the impact of trade agreements on access to quality essential medicines, and building capacity in the pharmaceutical sector all advocated and supported.</p> <p>5. Global norms, standards and guidelines for the quality, safety and efficacy of medicines strengthened and promoted.</p> <p>7. Awareness raising and guidance on cost-effective and sound use of medicines promoted, with a view to improving use of medicines by health professionals and consumers.</p>
Child and adolescent health	<p>3. Guidance and technical support provided and research conducted for increased coverage and intensified action towards improving neonatal and child survival, growth, and development.</p>
<p>(Briefly indicate the linkage with expected results, indicators, targets, baseline)</p> <p>The resolution is consistent with the expected results noted above and will ensure better access to essential medicines, including better medicines for children.</p> <p>The successful implementation of this resolution will assist in achieving the expected result and will be monitored by the appropriate indicators.</p>	
3. Financial implications	
<p>(a) Total estimated cost for implementation over the “life-cycle” of the resolution (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 20 320 000 over six years.</p> <p>(b) Estimated cost for the biennium 2006-2007 (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 8 300 000 are required in relation to the Proposed programme budget 2008–2009.</p> <p>(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? US\$ 800 000.</p>	
4. Administrative implications	
<p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions where relevant)</p> <p>Normative, technical and coordinating work will be performed at headquarters, which will be responsible for about 2/3 of the work (more in the first two years). Overall, 34% of the financial and human resources will be allocated to regions and countries.</p> <p>(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile)</p> <p>In order to perform this work in addition to existing programmes, the following supplementary staff are required: three staff in the professional category to assist with work on selection and quality of pharmaceuticals, together with 1.5 support staff in the general service category; one office-based staff member in the professional category at headquarters to coordinate technical collaboration with countries and regions. In addition, when the regional and country work commences, 0.5 professional and 0.5 general service-staff per region are likely to be required.</p> <p>(c) Time frames (indicate broad time frames for implementation and evaluation)</p> <p>Normative work has already begun and may be developed fully over the period 2007–2008. Regional and country activities will take place in the last four years of the programme.</p>	

1. Resolution EB120.R14 Health promotion in a globalized world	
2. Linkage to programme budget	
Area of work Health promotion	Expected result 5. Global partnership established to provide support to countries in implementing the recommendations of the 6th Global Conference on Health Promotion ... and its product, the Bangkok Charter for Health Promotion.
<p>(Briefly indicate the linkage with expected results, indicators, targets, baseline)</p> <p>Linkage to all indicators and targets for this expected result. Furthermore, in respect of the first indicator, capacity to promote health will be increased in 36 countries; and achievement in respect of the second indicator will include the development of four sets of action plans to fulfil the four commitments set out in the Bangkok Charter, namely, to make the promotion of health central to the global development agenda, a core responsibility for all governments, a key focus of communities and civil society and a requirement for good corporate practice.</p>	
3. Financial implications	
<p>(a) Total estimated cost for implementation over the “life-cycle” of the resolution (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 2 580 000, of which US\$ 1 005 000 will be required for the 7th Global Conference on Health Promotion, proposed to be held in 2009.</p> <p>(b) Estimated cost for the biennium 2006-2007 (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 790 000.</p> <p>(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? US\$ 100 000.</p>	
4. Administrative implications	
<p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions where relevant) Selected countries, all six regional offices and headquarters.</p> <p>(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile) One additional epidemiologist or social scientist is required.</p> <p>(c) Time frames (indicate broad time frames for implementation and evaluation) The term “life-cycle” refers to the period of four years encompassed by the bienniums 2006–2007 and 2008–2009.</p>	

1. Resolution EB120.R15 WHO's role and responsibilities in health research	
2. Linkage to programme budget	
Area of work	Expected result
Health information, evidence and research policy	3. Strengthened national health research for health-systems development, within the context of regional and international research and engagement of civil society; WHO programmes and initiatives in research for health-systems development and for access to, and use of, knowledge effectively developed and implemented on the basis of strategic priorities.
<p>(Briefly indicate the linkage with expected results, indicators, targets, baseline)</p> <p>The resolution will help to formulate a WHO "corporate" strategy for health research and will have an impact on the Organization's own priority-setting and management in respect of the research it supports, and will promote technical support to countries in core areas, including the following: health-systems research; research management and organization; monitoring of financial and human resources; capacity building; ethical review of research; and utilization of research in health policy development. It will also help to define WHO's role in health research with respect to the development of an Organization-wide strategy for research, and of linkages to other organizations; and will also inform the Global Ministerial Forum on Research for Health (to be held in Bamako, in November 2008).</p>	
3. Financial implications	
<p>(a) Total estimated cost for implementation over the "life-cycle" of the resolution (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 5 million are required for:</p> <p>(1) elaboration of a WHO research strategy, including support staff costs, travel, wide-ranging consultative and analytical processes, development of a reporting system, and writing; and</p> <p>(2) technical support to countries, including cost of training courses and workshops, development of various methodologies, and costs relating to travel and support staff.</p> <p>(b) Estimated cost for the biennium 2006-2007 (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 2 million</p> <p>(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? US\$ 300 000</p>	
4. Administrative implications	
<p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions where relevant) Headquarters, regional offices and selected country offices; dedicated WHO research centres (IARC, WHO Centre for Health Development, Kobe, Japan) and WHO collaborating centres.</p> <p>(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile) Two staff in the professional category with skills in (1) research policy and management, research governance, priority-setting, health-systems research, knowledge translation; and (2) ethical review of research involving human subjects, clinical research, bioethics and trials registration.</p>	

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

2006: establish an external reference group for the elaboration of WHO's research strategy, an internal steering group (with the participation of senior management) and draft objectives, strategic approaches, processes and timelines

2007: undertake consultations at regional and country levels, and with international partners; provide technical support to countries on various aspects of health research

End 2007: produce first draft of strategy

2008: report on progress to the Executive Board at its 122nd session and the Sixty-first World Health Assembly; continue to develop technical support to countries

End 2008: analyse and finalise the strategy, consult with regional offices for approval of the final draft

2009: submit draft strategy to the Executive Board at its 124th session and the Sixty-second World Health Assembly

2009 and beyond: implement strategy and define process for evaluating its impact; provide technical support.

1. Resolution EB120.R16 Malaria, including a proposal for establishment of World Malaria Day**2. Linkage to programme budget****Area of work**

Malaria

Expected result

1. Access of populations at risk to effective treatment of malaria promoted and facilitated through guidance on treatment policy and implementation.

2. Application of effective preventive measures against malaria for populations at risk promoted in disease-endemic countries.

3. Adequate support provided for capacity building in malaria control in countries.

4. Malaria-surveillance systems and monitoring and evaluation of control programmes functioning at country, regional and global levels.

5. Effective partnerships established and maintained for implementing the global Roll Back Malaria workplan to maximize countries' malaria-control performance.

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

The resolution, which builds on the revised strategies of the Global Malaria Programme and progress achieved towards malaria-control targets, provides the framework for achieving the malaria control-related expected results and targets outlined in the Programme Budget 2006–2007. Furthermore, the resolution is aligned with the expected results and indicators included in strategic objective 2 in the Draft Medium-term strategic plan for 2008–2013 that are relevant to malaria control.

3. Financial implications

- (a) Total estimated cost for implementation over the "life-cycle" of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)** To fulfil WHO's leadership role in supporting implementation of the revised strategies and directions for malaria control globally, an estimated US\$ 1302.5 million over the 10-year period (including the 2006–2007 biennium) will be required. These costs are in line with the current biennium workplan, and scale-up required under the Draft Medium-term strategic plan and the relevant strategic objectives.

<p>(b) Estimated cost for the biennium 2006-2007 (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 137 million plus US\$ 1 million required for global support of World Malaria Day in 2007 and US\$ 250 thousand to support the forum to improve coordination.</p> <p>(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? US\$ 69 million can be subsumed under existing programmed activities.</p>
<p>4. Administrative implications</p> <p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions where relevant)</p> <p>The response includes actions by all levels of the Organizations, including all regions and most country offices. All WHO core functions will be involved for each level of the Organization.</p> <p>(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile)</p> <p>Overall, at least six additional staff members will be required at headquarters over the period 2006–2015. However, some increase in staff over the decade will be needed in all regions in order to support expansion of activities especially in relation to improved indoor residual spraying and insecticide treated bednets interventions and impact evaluation. In addition, in the South-East Asia Region in the next year, additional staff especially in the area of monitoring and evaluation (e.g. two full-time), entomologists in the African and Eastern Mediterranean regions and national professional officers globally (e.g. at least 15 full-time equivalents) will be required to provide necessary technical cooperation, capacity building and surveillance associated with all malaria-control interventions.</p> <p>(c) Time frames (indicate broad time frames for implementation and evaluation)</p> <p>2006–2015. Evaluation of progress made towards 2015 targets will continue to the end of 2017 at least.</p>

<p>1. Resolution EB120.R17 Prevention and control of noncommunicable diseases: implementation of the global strategy</p>	
<p>2. Linkage to programme budget</p>	
<p>Area of work</p> <p>Surveillance, prevention and management of chronic, noncommunicable diseases</p>	<p>Expected results</p> <ol style="list-style-type: none"> 1. Support provided to countries for framing policies and strategies for prevention and management of chronic, noncommunicable diseases at national level, including integration of primary and secondary prevention into health systems. 2. Advocacy and provision of support for development of multisectoral strategies and plans to promote action on diet and physical activity in priority countries. 4. Effective guidance and support provided for implementation of WHO's surveillance framework for chronic, noncommunicable diseases and their risk factors. 5. Improved quality, availability, comparability and dissemination of data on chronic, noncommunicable diseases and their major modifiable risk factors.

<p align="center">(Briefly indicate the linkage with expected results, indicators, targets, baseline)</p> <p>The resolution will provide a framework for achieving expected results 1, 2, 4 and 5 related to surveillance, prevention and management of chronic, noncommunicable diseases.</p>	
<p>3. Financial implications</p> <p>(a) Total estimated cost for implementation over the “life-cycle” of the resolution (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 207 075 000</p> <p>(b) Estimated cost for the biennium 2006-2007 (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 59 164 000</p> <p>(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? US\$ 59 164 000 (all costs)</p>	
<p>4. Administrative implications</p> <p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions where relevant) Implementation of the resolution would require participation of all levels of the Organization, while implementation activities would be focused on low- and middle-income countries. Implementation would especially be focused on the 23 low- and middle-income countries that account for 80% of the burden of chronic, noncommunicable disease in low-income and middle-income countries.</p> <p>(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile) No additional staffing requirements are foreseen.</p> <p>(c) Time frames (indicate broad time frames for implementation and evaluation) Implementation will take place over the period 2007 to 2013.</p>	

<p>1. Resolution EB120.R21 Health technologies</p>					
<p>2. Linkage to programme budget</p> <table border="0"> <thead> <tr> <th align="left">Area of work</th><th align="left">Expected results</th></tr> </thead> <tbody> <tr> <td>Essential health technologies</td><td> <p>2. Capacity strengthened and quality and safety of, and access to, appropriate diagnostics, medical devices, laboratory services (including basic laboratory tests and screening for HIV, hepatitis B and C) and cell, organ and tissue transplantation services improved.</p> <p>4. Support provided to capacity building and to development of standard procedures, and model lists of essential medical devices used.</p> <p>5. Establishment of appropriate components of electronic information for use in health-care systems promoted and effectively supported.</p> <p>Expected results 1 and 3 are also relevant.</p> </td></tr> </tbody> </table> <p align="center">(Briefly indicate the linkage with expected results, indicators, targets, baseline)</p> <p>The resolution is fully consistent with the above-mentioned expected results and is linked to all indicators in the Programme budget 2006–2007. The establishment of a committee of experts on health technologies is in keeping with the strategic approach for this area of work, which includes policy and research work in essential health technologies in support of Member States. There are also considerable linkages to all technology-related indicators as the resolution calls for a broad-based technology programme that is not compartmentalized into specific technologies.</p>		Area of work	Expected results	Essential health technologies	<p>2. Capacity strengthened and quality and safety of, and access to, appropriate diagnostics, medical devices, laboratory services (including basic laboratory tests and screening for HIV, hepatitis B and C) and cell, organ and tissue transplantation services improved.</p> <p>4. Support provided to capacity building and to development of standard procedures, and model lists of essential medical devices used.</p> <p>5. Establishment of appropriate components of electronic information for use in health-care systems promoted and effectively supported.</p> <p>Expected results 1 and 3 are also relevant.</p>
Area of work	Expected results				
Essential health technologies	<p>2. Capacity strengthened and quality and safety of, and access to, appropriate diagnostics, medical devices, laboratory services (including basic laboratory tests and screening for HIV, hepatitis B and C) and cell, organ and tissue transplantation services improved.</p> <p>4. Support provided to capacity building and to development of standard procedures, and model lists of essential medical devices used.</p> <p>5. Establishment of appropriate components of electronic information for use in health-care systems promoted and effectively supported.</p> <p>Expected results 1 and 3 are also relevant.</p>				

3. Financial implications

- (a) **Total estimated cost for implementation over the “life-cycle” of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)** US\$ 5.2 million are required per biennium (US\$ 4.1 million for staff costs and US\$ 1.1 million for operational costs, including technical assistance to Member States).
- (b) **Estimated cost for the biennium 2006-2007 (estimated to the nearest US\$ 10 000, including staff and activities)** Estimated total cost is US\$ 3.9 million.
- (c) **Of the estimated cost noted in (b), what can be subsumed under existing programmed activities?** US\$ 1.7 million can be subsumed under existing headquarters funds for human resources and activities.

4. Administrative implications

- (a) **Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions where relevant)**
This will involve work throughout the Organization, in particular in the regions and countries that do not have the resources to support an effective health technology programme.
- (b) **Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile)**
Seven additional full-time staff will be required across the Organization, together with six half-time support staff. One staff member in the professional category and one at 50% in the general service category will be required at headquarters to support the development of guidelines and standards for health technologies; six regional advisers and five support staff at 50% will be needed in the regional offices to facilitate regional and country work.
- (c) **Time frames (indicate broad time frames for implementation and evaluation)**
Implementation of the resolution will be part of the continuing programmatic work in respect of essential health technologies and will therefore be subject to the same periodic evaluation as WHO's other activities in this area.

1. Decision EB120(1) Confirmation by the United Nations General Assembly of the International Civil Service Commission's general framework, including implementation and cost of amendments to Staff Rules

2. Linkage to programme budget

Area of work

Human resources management in WHO

Expected result

4. Conditions of service improved and staff-friendly policies implemented; WHO pay and benefits system brought into line with the United Nations field-oriented organizations' system.

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

The improved conditions of service outlined in the contract reform proposal represent the implementation of a staff-friendly policy that aims to ensure that the Organization attracts and retains the highest calibre of staff.

3. Financial implications

- (a) **Total estimated cost for implementation over the “life-cycle” of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)** US\$ 8.6 million. These revised figures relate to the reduced additional costs that will result from improvement of the conditions of service for temporary staff, applying the principle of equal pay for equal work, which had not been foreseen in the Programme budget 2006–2007. The delay in implementation of these measures impacts on reduced costs related to the education grant, assignment grant, home leave and education-grant travel. The cost for future bienniums will be subsumed within the revised

staff costs projected for each budgeting cycle, and will be in accordance with the need for temporary functions, as foreseen at that time.

(b) Estimated cost for the biennium 2006-2007 (estimated to the nearest US\$ 10 000, including staff and activities) The costs indicated in (a) above are estimated for 2007, which corresponds to the period of implementation of the proposed new measures.

(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? None of the proposed additional costs can be subsumed under existing programme activities as all those concerned are in the process of converting a number of temporary functions into fixed-term positions; the amount indicated, therefore represents the estimated net increase over and above present budgets.

4. Administrative implications

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

Implementation would be Organization-wide, using the revised human resource plans from both regional offices and headquarters.

(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile)

Implementation of the proposed contract reform does not require additional staffing.

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

Implementation will take place throughout 2007.