

ANNEXES

ANNEX 1

Action plan for the prevention of avoidable blindness and visual impairment¹

[A62/7 – 2 April 2009]

1. According to the latest WHO estimates, about 314 million people worldwide live with visual impairment due to either eye diseases or uncorrected refractive errors. Of these, 45 million are blind, of whom 90% live in low-income countries. The major causes of blindness are cataract (39%), uncorrected refractive errors (18%), glaucoma (10%), age-related macular degeneration (7%), corneal opacity (4%), diabetic retinopathy (4%), trachoma (3%), eye conditions in children (3%), and onchocerciasis (0.7%). The actual magnitude of blindness and visual impairment is likely to be higher than estimates indicate, as detailed epidemiological information on some causes (e.g. presbyopia) is still lacking.

2. With today's knowledge and technology, up to 80% of global blindness is preventable or treatable. Cost-effective interventions are available for the major causes of avoidable blindness. Major international partnerships have been established in recent years, including the African Programme for Onchocerciasis Control, the Onchocerciasis Elimination Program for the Americas, the WHO Alliance for the Global Elimination of Blinding Trachoma and VISION 2020: the Right to Sight.

3. Two recently adopted Health Assembly resolutions (WHA56.26 and WHA59.25) focused on avoidable blindness and visual impairment, urging Member States to work on prevention, mainly through specific plans and inclusion of the subject in national health plans and programmes. Despite significant progress in the area of eye health, the prevalence of avoidable blindness remains unacceptably high in many countries and communities.

PURPOSE

4. The plan aims to expand efforts by Member States, the Secretariat and international partners in preventing blindness and visual impairment by developing comprehensive eye-health programmes at national and subnational levels.

5. In order to intensify and coordinate existing activities, especially in low- and middle-income countries, the plan seeks to:

- (a) increase political and financial commitment to eliminating avoidable blindness;
- (b) facilitate the preparation of evidence-based standards and guidelines, and use of the existing ones, for cost-effective interventions;

¹ See resolution WHA62.1.

- (c) review international experience and share lessons learnt and best practices in implementing policies, plans and programmes for the prevention of blindness and visual impairment;
- (d) strengthen partnerships, collaboration and coordination between stakeholders involved in preventing avoidable blindness;
- (e) collect, analyse and disseminate information systematically on trends and progress made in preventing avoidable blindness globally, regionally and nationally.

SCOPE

6. This plan focuses on the major causes of avoidable blindness and visual impairment, as defined in the draft eleventh revision of the International Statistical Classification of Diseases and Related Health Problems.¹ The plan does not deal with categories of milder visual impairment or eye conditions for which evidence-based prevention and/or treatment interventions are not available; these cases will require effective and appropriate rehabilitation measures that enable people with disabilities to attain and maintain maximum independence and full inclusion and participation in all aspects of life.

7. Since blinding conditions are chronic and mostly due to noncommunicable causes, this plan complements the action plan for the global strategy for the prevention and control of noncommunicable diseases adopted by the Health Assembly in resolution WHA61.14. Prevention strategies differ significantly, however, as most blinding conditions do not share the risk factors, other than tobacco use, addressed in the noncommunicable disease plan. Although, as with noncommunicable diseases, primary health-care and community-based interventions are essential for preventing blindness and visual impairment, the provision of high-quality eye-care services needs specific skills, technology and infrastructure.

8. Evidence indicates that the magnitude of avoidable blindness caused by communicable diseases like trachoma and onchocerciasis and ophthalmological complications in measles is decreasing, whereas noncommunicable age-related eye conditions (e.g. cataract, glaucoma and diabetic retinopathy) are increasing. Programmes against both onchocerciasis and trachoma need continued efforts for control and to avoid recurrence. A coordinated intersectoral approach to both communicable and noncommunicable conditions is needed.

9. In view of the adverse global economic climate it is essential to maximize the impact of existing resources and technical programmes across WHO that contribute to the prevention of blindness, and also influence the conditions that make populations vulnerable to visual impairment. An example of this is the use of immunization, and vitamin A supplementation in vulnerable populations, to reduce the risk of blindness due to corneal opacities.

¹ “Blindness” is defined as a presenting visual acuity of less than 3/60, or a corresponding visual field loss to less than 10° in the better eye with the available correction. “Severe visual impairment” is defined as a presenting visual acuity of between less than 6/60 and 3/60, and “moderate visual impairment” is defined as a presenting visual acuity of less than 6/18 to 6/60. In this document “visual impairment” includes both severe and moderate visual impairment.

RELATION TO EXISTING STRATEGIES AND PLANS

10. Prevention of avoidable blindness and visual impairment has been the subject of several resolutions adopted by the Health Assembly,¹ which, inter alia, encouraged several international partnerships and alliances to work at the global level in this field. The action plan supports implementation of WHO's Eleventh General Programme of Work 2008–2013 and the Medium-term strategic plan 2008–2013, particularly strategic objective 3, which covers work on prevention and control of avoidable blindness and visual impairment. It also supports the implementation of existing regional resolutions and plans.²

RESOURCES

11. The Programme budget 2008–2009 describes the financial resources required by the Secretariat for work to meet strategic objective 3. For future bienniums, additional resources will be required. Further progress in preventing avoidable blindness and visual impairment globally, regionally and nationally will depend on the amount of additional resources available. All partners – including intergovernmental and nongovernmental organizations, academic and research institutions and the private sector – will need to do more for resource mobilization at all levels.

TIME FRAME

12. This action plan is designed to cover the period 2009–2013, that is, the remaining five years of the Medium-term strategic plan.

SITUATION ANALYSIS

Magnitude, causes and impact of blindness and visual impairment

13. Determining the causes and magnitude of blindness is necessary for setting priorities, designing targeted strategies and establishing international blindness-prevention cooperation and alliances. Recent years have seen much better availability of data on the causes and magnitude of blindness and visual impairment around the world. In the past, surveys on the causes used a variety of methods and definitions, but WHO's development of standardized and feasible methodologies has facilitated collection from Member States of comparable epidemiological and health-system data, for example on the rapid assessment of surgical services for cataract and of avoidable blindness. The childhood blindness protocol is another example of such progress.

14. To date, epidemiological surveys have been conducted in 65 countries. However, the absence of surveys and lack of data in the remaining countries have greatly hampered detailed planning, monitoring and evaluation of interventions. In addition, missing epidemiological data on the status of

¹ Resolutions WHA22.29, WHA25.55, WHA28.54, WHA47.32, WHA51.11, WHA56.26 on elimination of avoidable blindness and WHA59.25 on prevention of avoidable blindness and visual impairment.

² See resolution EM/RC49/R.6 on VISION 2020: The Right to Sight – elimination of avoidable blindness, resolution EM/RC52/R.3 on Prevention of avoidable blindness and visual impairment, document AFR/RC57/6 (Accelerating the elimination of avoidable blindness – a strategy for the WHO African Region) and PAHO: Draft Ocular Health Strategy and Plan of Action 2008–2012.

visual health in the population limits further analysis of the trends of visual impairment and the timely development of appropriate public health interventions.

15. Collection of reliable and standardized epidemiological data is a priority for countries where such data are not available. Action is also needed to develop modelling approaches in order to determine trends and set targets, so that the planning of efforts to prevent avoidable blindness and visual impairment can be more focused and evidence-based. Also required is an improved mechanism for systematically collecting standardized information on human resources, infrastructure and available technologies, and countries must be ready to respond to the observed needs.

Prevention of blindness and visual impairment as part of national health development plans and WHO technical collaboration with Member States

16. Despite the availability of WHO information on the magnitude and causes of blindness and strategies for their prevention, policy-makers and health providers in some countries are evidently not fully aware of available eye-care interventions, their cost-effectiveness and their potential to prevent or treat the 80% of global blindness that is avoidable. Country cooperation strategies reflect the agreed joint agenda between health ministries and WHO. So far, the inclusion of blindness prevention in such documents has been minimal, despite seven resolutions of the Health Assembly relating to prevention of avoidable blindness and visual impairment, the existence of WHO's major, long-standing international partnerships on prevention of blindness, and major successes in reducing avoidable blindness, such as WHO's Onchocerciasis Control Programme. Lack of adequate resources for preventing blindness at the country level is a major impediment. Additionally, faced with increasingly limited resources, donor and recipient countries often give higher priority to mortality-related disease control programmes than to those dealing with problems of disability. Also, experienced staff to coordinate blindness-prevention activities at the regional and country levels are in short supply.

17. Greater priority should be given to preventing blindness in health development plans and country cooperation strategies. Action is also needed to strengthen technical support and enhance the provision of expert advice to Member States where blindness and visual impairment are a major health problem.

National eye health and prevention of blindness committees

18. It is important to establish national committees and programmes for eye health and blindness prevention. Their role is to liaise with all key domestic and international partners, to share information and to coordinate such activities as implementing the national eye health and blindness-prevention plan. A functional national committee is a prerequisite for developing the national blindness-prevention plan and its implementation, monitoring and periodic assessment. Some countries, particularly those with decentralized or federated management structures, have similar committees at subnational level.

19. By the end of 2008, 118 Member States had reported the establishment of a national committee. However, not all national committees are functional and, unfortunately, in many cases such committees have not successfully initiated effective action. In some instances, selected individuals, often dedicated eye-care professionals, are relied on to provide leadership and serve as the driving force for blindness-prevention plans and programmes. The committees' membership is often not uniform, ranging from the ideal scenario, in which all key partners are represented (including the national health-care authorities), to a minimal group of dedicated eye-care professionals.

National eye health and prevention of blindness plans

20. Experience has shown that, in low- and middle-income countries, a comprehensive national plan containing targets and indicators that are clearly specified, time-linked and measurable leads to substantially improved provision of eye health-care services.

21. Most low- and middle-income countries (104 Member States by the end of 2008) have reported the development of national eye health and blindness-prevention plans, but reporting on and assessment of their implementation and impact have been insufficient. Some national plans do not include measurable targets, an implementation timeline and adequate tools for monitoring and evaluation. In some countries, the plans have only been partially implemented. In addition, because of lack of resources and leadership, some countries have made only slow or fragmented progress and their plans for eye health and national prevention of blindness have not yielded tangible improvements in the provision of eye-care services. It is necessary to ensure that the implementation phase of national plans is well managed, and a standardized approach to monitoring and evaluation of national and subnational eye health and blindness-prevention plans must be taken.

WHO's strategies for prevention of blindness and visual impairment and provision of technical support

22. WHO's strategy for the prevention of avoidable blindness and visual impairment is based on three core elements: strengthening disease control, human resource development, and infrastructure and technology. This approach has been promoted since 1999 by the global initiative "VISION 2020: the Right to Sight", which was established as a partnership between WHO and the International Agency for the Prevention of Blindness. The past decade has seen major progress in the development and implementation of WHO's approaches to controlling communicable causes of blindness and visual impairment. Achievements in controlling onchocerciasis and trachoma were based, respectively, on implementation of WHO's strategies of community-directed treatment with ivermectin and the SAFE strategy for trachoma control, and their adoption by Member States and international partners. This unified approach facilitated preventive efforts aimed at millions of individuals at risk of visual loss, and convinced major donors that long-term commitment is required.

23. Subsequently, major shifts in the pattern of causes of blindness have been documented, with a declining trend for the communicable causes and a progressive increase in age-related chronic eye conditions. Public health interventions for some of the major conditions such as cataract and diabetic retinopathy have been systematically reviewed and respective WHO recommendations have been formulated. Strategies are needed to control other conditions such as glaucoma.

24. By the end of 2008, 150 Member States have held national or subnational VISION 2020 workshops to introduce WHO's strategies for eye health. These workshops were the platform for sharing expertise about community eye health and facilitated the process of needs assessment and subsequent formulation of national and subnational blindness-prevention plans.

Prevention of avoidable blindness and visual impairment as a global health issue

25. Reliable epidemiological data and the availability of cost-effective interventions for the control of most of the major causes of avoidable blindness have demonstrated the importance of strengthening national initiatives in preserving eye health. In resolutions WHA56.26 and WHA59.25, the Health Assembly recommended a unified approach to blindness-prevention activities, urging Member States to establish national committees, to set up national blindness-prevention plans, and to devise strong monitoring and evaluation mechanisms for their implementation. In addition, it has been recognized

that advocacy for preventing visual loss needs to reach a wider audience, and that the importance of preserving eye health needs to be further promoted in the public health domain and the community.

26. In some countries the impact of Health Assembly resolutions on allocation of new resources for development and implementation of blindness-prevention plans has fallen short of expectations. In most countries action is slow and progress in implementing adequate blindness-prevention activities is limited.

27. Plans and programmes on blindness prevention exist at global level and in some cases at regional and national levels, but action is now required to provide support to Member States that have not yet developed such programmes in applying international experience and scientific evidence in order to develop and implement their own blindness-prevention measures. Action is also required to integrate the eye-health agenda and its impact on poverty alleviation in the overall development agenda.

International partnerships

28. Over the past decade, major international partnerships have been forged to assist WHO in providing support to Member States in their efforts to prevent blindness, such as “VISION 2020: the Right to Sight”. The partnerships have made substantial progress, mostly in combating infectious causes of blindness. They have also encouraged and supported long-term resource mobilization, including donation programmes (e.g. the Merck donation programme for ivermectin to control onchocerciasis, and distribution of azithromycin under a donation programme by Pfizer to control trachoma). Global partnerships have united and substantially strengthened the key international stakeholders in their action to prevent blindness, using WHO disease control strategies.

29. Coordination and timely evaluation of work undertaken by international partners is required so that their approaches are aligned with other activities in the area of blindness prevention. Despite some notable improvements in collecting data on blindness-prevention activities at the country and subnational levels, consolidated reporting remains limited. One reason is the weakness of many countries’ monitoring systems, another being the limited information sharing and exchange between countries and their international partners.

30. The action now required is to improve coordination and information exchange between all stakeholders.

Human resources and infrastructure

31. Despite efforts to strengthen human resources for eye health, a crucial shortage of eye-care personnel persists in many low-income countries. Many countries in the African Region, for instance, have less than one ophthalmologist per million inhabitants. In addition, the existing human resources are often concentrated in larger urban agglomerations, leaving the rural areas with a poor or non-existent service. Furthermore, well-trained personnel leave low-paid positions in many of the public and university health-care establishments, seeking work in the domestic private health-care sector or even work opportunities abroad. It is thus the poorest areas of low-income countries that are most seriously disadvantaged by a suboptimal workforce beset by shortages, low productivity and uneven distribution.

32. Although recent technological developments in eye care have resulted in advanced methods of diagnostics and treatment, the cost of properly equipping a secondary and/or tertiary eye-care centre is prohibitive for many low-income countries.

33. Urgent action is required within countries to train more eye-health personnel and redress the distribution of the available workforce between urban and rural areas.

Resource mobilization

34. Strong international partnerships have been instrumental in convincing international and domestic donors to support blindness-prevention activities (e.g. the African Programme for Onchocerciasis Control, the Onchocerciasis Elimination Program for the Americas, the WHO Alliance for the Global Elimination of Blinding Trachoma, and VISION 2020: the Right to Sight). Despite these disease-specific achievements, there have been major shortfalls in the resources available for national programmes of eye health and blindness prevention. Moreover, the potential for generating additional international and domestic resources has not been fully explored. The lack of adequate resources for blindness prevention and visual impairment activities could seriously jeopardize advances in eye-health care.

35. The action now required is to review the current approaches to financing eye-health systems, highlight the socioeconomic impact of blindness, the cost-effectiveness of eye-health interventions, and the financial benefits of early prevention of blindness and visual impairment.

Integration of eye health into broad development plans

36. The creation of comprehensive, integrated health services and sharing of resources and infrastructure will be facilitated by incorporating eye health in broader intersectoral development plans. An added value was recorded in countries where prevention of blindness was integrated into the broader health development plans and/or socioeconomic development programmes.

37. Despite reported links between visual impairment and decreased socioeconomic opportunities for the affected individuals, prevention of blindness has not been sufficiently addressed in many major international and domestic development agendas. There has been insufficient research on the impact of blindness in various socioeconomic settings as well as on limitations of access to eye care for low-income groups, and the action now required is to promote further research in these areas.

OBJECTIVES AND ACTION

OBJECTIVE 1. Strengthen advocacy to increase Member States' political, financial and technical commitment in order to eliminate avoidable blindness and visual impairment

38. International advocacy for the preservation of visual health aims to increase awareness of current blindness-prevention plans, especially the cost-effective interventions available and international experience in their implementation. This advocacy effort should target health-care professionals and policy-makers in order to encourage the intersectoral action needed to improve eye health-care systems, to integrate them in national health systems, and incorporate eye health in broader health-care and development plans. It should also target potential donors and those who set research priorities and funding levels so as to accumulate evidence on prevention of blindness and visual impairment and their impact.

39. Further research is needed on the impact of risk factors such as smoking, ultraviolet radiation and lack of hygiene. Inequities in access to eye-care services also need to be further researched.

40. Special attention should be paid to raising public awareness and finding appropriate ways of communicating information on prevention of visual loss and ways of treating eye conditions.

Proposed action for Member States

41. Establish and support national coordinating mechanisms, such as national coordinators posts for eye health and prevention of blindness at health ministries and other key institutions, as appropriate.
42. Consider budgetary appropriations for eye health and prevention of blindness.
43. Promote and integrate eye health at all levels of health-care delivery.
44. Observe World Sight Day.
45. Integrate eye-health preservation in health promotion agendas.

Action for the Secretariat

46. Conduct political analyses to determine the best way of securing support of high-level decision-makers and their commitment to promoting eye health, and explore the potential impact and ways of integrating blindness prevention in socioeconomic policies and programmes [2009–2011].
47. Make policy-makers aware of the relationship between eye diseases, gender, poverty and development, using evidence-based information and epidemiological data and take forward the work on social determinants of health as it relates to eye-health problems [2009–2010].
48. Harmonize the advocacy messages used by international partners in various health and development forums [2009–2010].
49. Promote collaboration by programmes and groups across the Organization in work on tackling major risk factors for visual impairment.

Proposed action for international partners

50. Support WHO in involving all stakeholders in advocacy in order to raise awareness of the magnitude of blindness and visual impairment, the availability of cost-effective interventions, and international experience in applying them.
51. Support Member States in establishing forums where key stakeholders – including nongovernmental organizations, professional associations, academia, research institutions and the private sector – can agree on concerted action against avoidable blindness and visual impairment.

OBJECTIVE 2. Develop and strengthen national policies, plans and programmes for eye health and prevention of blindness and visual impairment

52. National policies, plans and programmes for eye health and prevention of avoidable blindness and visual impairment are essential instruments for coordinated, evidence-based, cost-effective, sustainable interventions. Integration of eye health into relevant national health policies, including those relating to school and occupational health, facilitates a coordinated multidisciplinary approach and development of comprehensive eye care, with emphasis on primary eye care.
53. Evidence-based WHO strategies for tackling several main causes of avoidable blindness and visual impairment have been designed in order to support the formulation of policies and programmes. Some strategies are already in place for the control of trachoma, onchocerciasis, vitamin A deficiency,

diabetic retinopathy and some aspects of cataract-related visual loss, but strategies for emerging major causes of visual loss need to be developed.

Proposed action for Member States

54. Where sufficient capacity exists, develop national strategies and corresponding guidelines for the prevention of blindness and visual impairment; otherwise consider adapting those recommended by WHO.
55. Review existing policies addressing visual health, identify gaps and develop new policies in favour of a comprehensive eye-care system.
56. Incorporate prevention of blindness and visual impairment in poverty-reduction strategies and relevant socioeconomic policies.
57. Involve relevant government sectors in designing and implementing policies, plans and programmes to prevent blindness and visual impairment.
58. Develop an eye-health workforce including paramedical professionals and community health workers through training programmes that include a community eye-health component.

Action for the Secretariat

59. Review the experience of public health strategies for the control of uncorrected refractive errors including presbyopia, glaucoma, age-related macular degeneration, corneal opacity, hereditary eye disease, and selected eye conditions in children including sequelae of vitamin A deficiency [2009–2011].
60. Facilitate establishment and activities of eye health and national blindness-prevention committees, advise Member States on their composition, role and function, and provide direct technical support for developing, implementing and evaluating national plans.
61. Develop a coordinated and standardized approach to the collection, analysis and dissemination of information on the implementation of national eye health-related policies, best practices in the public health aspects of blindness prevention, including information on the available health insurance systems, and their impact on the various aspects of eye-care provision [2009–2011].
62. Promote collaboration with other major programmes and partnerships (e.g. the WHO Global Health Workforce Alliance) to promote the development of human resources for eye-care provision at primary, secondary and tertiary levels [2009–2010].
63. Review educational curricula and best practices for education and training of eye health-care professionals [2010–2011].
64. Strengthen the capacity of regional and country offices to provide technical support for eye health/prevention of blindness.

Proposed action for international partners

65. Promote WHO-recommended strategies and guidelines for prevention of blindness and visual impairment, and, with the assistance of Member States, contribute to the collection of national information on their implementation.

66. Generate resources for, and support the implementation of, national blindness-prevention plans in order to avoid duplication of effort.

67. Provide continued support to programmes controlling nutritional and communicable causes of blindness.

OBJECTIVE 3. Increase and expand research for the prevention of blindness and visual impairment

68. Public-health action to prevent blindness and visual impairment needs to be evidence-based and cost-effective. International collaboration in promoting multidimensional and multisectoral research is essential for developing eye-care systems that are comprehensive, integrated, equitable, high-quality and sustainable. Further research is needed on ways to capitalize on available evidence. Special emphasis should be placed on evaluating interventions and different strategies for early detection and screening of the causes of blindness and visual impairment in different population groups, including children.

Proposed action for Member States

69. Promote research by national research institutions on socioeconomic determinants, the role of gender, the cost-effectiveness of interventions, and identification of high-risk population groups.

70. Assess the economic cost of blindness and visual impairment and its impact on socioeconomic development.

71. Determine the impact of poverty and other determinants on the gradient of socioeconomic disparity in individuals' access to eye-care services.

72. Include epidemiological, behavioural, health-system and health-workforce research as part of national programmes for eye health and prevention of blindness and visual impairment.

Action for the Secretariat

73. Collate, in collaboration with other partners, existing data on risk factors, such as smoking, unhealthy diet, physical inactivity, ultraviolet radiation and lack of hygiene, and coordinate the development of a prioritized research agenda related to the causes and prevention of blindness with special emphasis on low- and middle-income countries [2009–2011].

74. Support Member States in assessing the impact of public health policies and strategies on the status of eye health and share the results.

75. Facilitate development of projection models on trends in the causes and magnitude of blindness and visual impairment and prioritize development of, and target setting for, eye-care systems [2010–2011].

Proposed action for international partners

76. Support low- and middle-income countries in building capacity for epidemiological and health systems research, including the analytical and operational research required for programme implementation and evaluation in the area of eye disease.

77. Support collaboration between institutions in low- and middle-income countries and high-income countries.

78. Support and prioritize in coordination with Member States research on eye diseases at the global, regional and subregional levels.

79. Strengthen and support WHO Collaborating Centres and national research institutions in research related to prevention of blindness and visual impairment.

OBJECTIVE 4. Improve coordination between partnerships and stakeholders at national and international levels for the prevention of blindness and visual impairment

80. Large international partnerships and alliances have been instrumental in developing effective public health responses for the prevention of blindness and visual impairment. Member States, United Nations agencies, other international institutions, academia, research centres, professional health-care organizations, nongovernmental organizations, service organizations, civil society and the corporate sector are key stakeholders in this process. The challenges are to strengthen global and regional partnerships and to incorporate the prevention of blindness into broader development initiatives that include efforts to establish new intersectoral forms of collaboration and alliances.

Proposed action for Member States

81. Promote participation in, and actively support, existing national and international partnerships and alliances for the prevention of avoidable blindness and visual impairment, including coordination with noncommunicable disease control programmes and neglected tropical disease prevention and control.

82. Promote partnerships between the public, private and voluntary sectors at national and subnational levels.

Action for the Secretariat

83. Convene the WHO Monitoring Committee for the Elimination of Avoidable Blindness pursuant to resolution WHA56.26 [2009].

84. Support and strengthen the role of WHO Collaborating Centres by linking their workplans to the implementation of this plan [2009–2010].

Proposed action for international partners

85. Collaborate closely with and provide support to Member States and the Secretariat in implementing the various components of this plan.

86. Liaise with other international organizations and agencies with broader development agendas in order to identify opportunities for collaboration.

87. Continue to support the existing partnerships for onchocerciasis and trachoma control until these diseases are eliminated as public health problems.

OBJECTIVE 5. Monitor progress in elimination of avoidable blindness at national, regional and global levels

88. Information on causes, the magnitude and geographical distribution of blindness and visual impairment, together with their trends, is essential for evidence-based advocacy and planning. Likewise, understanding the constraints and gaps in current service delivery and monitoring how these are corrected by Member States are crucial to successful implementation. Necessary and timely adjustments can only be made on the basis of continuous monitoring and periodic evaluation of action to prevent blindness.

Proposed action for Member States

89. Provide regularly updated data and information on prevalence and causes of blindness and visual impairment, disaggregated by age, gender and socioeconomic status.

90. Strengthen standardized data collection and establish surveillance systems using existing WHO tools (for example, those used for cataract, trachoma and onchocerciasis).

91. Provide regular reports using the WHO standardized reporting system, on progress made in implementing national blindness-prevention strategies and plans.

Action for the Secretariat

92. In collaboration with the main stakeholders, review and update the list of indicators for monitoring and periodic evaluation of action to prevent blindness and visual impairment, and determine targets and timelines [2009–2011].

93. Review data inputs in order to determine the impact of action to prevent avoidable blindness and visual impairment at country level, with the aim of showing a reduction in the magnitude of avoidable blindness, pursuant to resolution WHA56.26 [2009–2011].

94. Document, from countries with successful blindness prevention programmes, good practices and blindness prevention systems or models that could be modified or applied in other countries, pursuant to resolution WHA56.26 [2009–2010].

95. Initiate periodic independent evaluation of work on preventing blindness and visual impairment, including that of international partnerships, to be reviewed by the WHO Monitoring Committee for the Elimination of Avoidable Blindness [2009–2010].

96. Contribute to the Global Burden of Disease 2005 study¹ [2009–2010].

Proposed action for international partners

97. Provide collaborative support to Member States and the Secretariat in monitoring and evaluating progress in prevention and control of blindness and visual impairment at regional and global levels.

¹ <http://www.globalburden.org>.

98. Collaborate with WHO in establishing a network for review of regional and global monitoring and evaluation of progress in the prevention of blindness and visual impairment.

INDICATORS

99. In order to assess trends in the causes of blindness and visual impairment, to measure the progress made by Member States in preventing blindness and visual impairment, and to monitor implementation of this action plan, a set of core process and outcome indicators needs to be identified and defined. The indicators will mostly focus on action taken by the Secretariat and by Member States. Each country may develop its own set of indicators based on priorities and resources; however, in order to track progress globally and regionally, data and information collection needs to be standardized. The current set of indicators used by WHO in monitoring and reporting on the global status of the prevention of blindness and visual impairment¹ should be reviewed and updated. Baseline values are available in WHO for many of the indicators; for those for which there are no baseline values, mechanisms will be established for collecting relevant data.

¹ Document WHO/PBL/03.92.

ANNEX 2

Financial Regulations of the World Health Organization¹

[A62/32 – 26 March 2009]

Regulation I – Applicability and delegation of authority

- 1.1 These Regulations shall govern the financial administration of the World Health Organization.
- 1.2 The Director-General is responsible for ensuring effective financial administration of the Organization in accordance with these Regulations.
- 1.3 Without prejudice to Regulation 1.2 the Director-General may delegate in writing to other officers of the Organization such authority and related accountability as he or she considers necessary for the effective implementation of these Regulations.
- 1.4 The Director-General shall establish Financial Rules, including relevant guidelines and limits for the implementation of these Regulations, in order to ensure effective financial administration, the exercise of economy, and safeguard of the assets of the Organization.

Regulation II – The financial period

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

Regulation III – The budget

- 3.1 The budget estimates for the financial period, as referred to in Article 55 of the Constitution (hereinafter referred to as “budget proposals”), shall be prepared by the Director-General. The budget proposals shall be presented in United States dollars.
- 3.2 The budget proposals shall be divided into parts, sections and chapters, and shall include such information, annexes and explanatory statements as may be requested by, or on behalf of, the Health Assembly and such further annexes or statements as the Director-General may deem necessary and useful.
- 3.3 The Director-General shall submit the budget proposals at least 12 weeks before the opening of the regular session of the Health Assembly, and before the opening of the appropriate session of the Executive Board, at which they are to be considered. At the same time, the Director-General shall transmit these proposals to all Members (including Associate Members).

¹ Text amended in accordance with resolution WHA62.6.

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

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

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

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

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

Regulation IV – Regular budget appropriations

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

4.2 Appropriations shall be available for making commitments in the financial period to which they relate for delivery in that financial period or the subsequent calendar year.

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

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

Regulation V – Provision of regular budget funds

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

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

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

Regulation VI – Assessed contributions

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

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

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

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

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

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

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

6.8 Payments made by a Member shall be credited to the Member's account and applied first against the oldest amount outstanding.

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

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

6.11 New Members shall be required to make a contribution for the financial period in which they become Members at rates to be determined by the Health Assembly. Such contributions shall be recorded as income in the year in which they are due.

Regulation VII – Working Capital Fund and internal borrowing

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

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

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

Regulation VIII – Revenue: other sources

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

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

Regulation IX – Funds

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

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

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

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

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

Regulation X – Custody of cash and cash equivalents

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

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

Regulation XI – Investment of cash and cash equivalents

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

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

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

Regulation XII – Internal control

12.1 The Director-General shall:

- (a) establish operating policies and procedures in order to ensure effective financial administration, the exercise of economy, and safeguard of the assets of the Organization;
- (b) designate the officers who may receive funds, incur financial commitments and make payments on behalf of the Organization;
- (c) maintain an effective internal control structure to ensure the accomplishment of established objectives and goals for operations; the economical and efficient use of resources; the reliability and integrity of information; compliance with policies, plans, procedures, rules and regulations; and the safeguarding of assets;
- (d) maintain an internal audit function which is responsible for the review, evaluation and monitoring of the adequacy and effectiveness of the Organization's overall systems of internal control. For this purpose, all systems, processes, operations, functions and activities within the Organization shall be subject to such review, evaluation and monitoring.

Regulation XIII – Accounts and financial statements

13.1 The Director-General shall establish such accounts as are necessary and shall maintain them in accordance with International Public Sector Accounting Standards.

13.2 Financial statements shall be prepared annually in accordance with International Public Sector Accounting Standards, together with such other information as may be necessary to indicate the current financial position of the Organization.

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

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

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

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

Regulation XIV – External audit

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

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

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

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

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

14.6 The Director-General shall provide the External Auditor(s) with the facilities required for the performance of the audit.

14.7 For the purpose of making a local or special examination or for effecting economies of audit cost, the External Auditor(s) may engage the services of any national Auditor-General (or equivalent title) or commercial public auditors of known repute or any other person or firm that, in the opinion of the External Auditor(s), is technically qualified.

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

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

Regulation XV – Resolutions involving expenditures

15.1 Neither the Health Assembly nor the Executive Board shall take a decision involving expenditures unless it has before it a report from the Director-General on the administrative and financial implications of the proposal.

15.2 Where, in the opinion of the Director-General, the proposed expenditure cannot be made from the existing appropriations, it shall not be incurred until the Health Assembly has made the necessary appropriations.

Regulation XVI – General provisions

16.1 These Regulations shall be effective as of the date of their approval by the Health Assembly, unless otherwise specified by the Health Assembly. They may be amended only by the Health Assembly.

16.2 In case of doubt as to the interpretation and application of any of the foregoing regulations, the Director-General is authorized to rule thereon, subject to confirmation by the Executive Board at its next session.

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

ANNEX 3

Amendments to the Staff Regulations¹

[A62/36 – 9 April 2009]

IV. APPOINTMENT AND PROMOTION

...

- 4.2 The paramount consideration in the appointment, transfer, reassignment or promotion of the staff shall be the necessity of securing the highest standards of efficiency, competence and integrity. Due regard shall be paid to the importance of recruiting and maintaining the staff on as wide a geographical basis as possible.
- 4.3 Selection of staff members shall be without regard to race, creed or sex. So far as is practicable, selection shall be made on a competitive basis; however, the foregoing shall not apply to the filling of a position by transfer or reassignment of a staff member without promotion in the interest of the Organization.

...

¹ Resolution WHA62.7.

ANNEX 4

Plan of action on public health, innovation and intellectual property¹

[A62/16 Add.1 – 26 March 2009]

1. The Sixty-first World Health Assembly adopted the global strategy² and the agreed parts of the plan of action on public health, innovation and intellectual property in resolution WHA61.21. That resolution requested the Director-General, inter alia, to finalize the outstanding components of the plan of action, including time frames and estimated funding needs, and submit the final plan for consideration by the Sixty-second World Health Assembly through the Executive Board. The Board at its 124th session took note of the Secretariat's report on the global strategy and plan of action.³

2. The Secretariat has undertaken further work to propose time frames for the specific actions in the plan of action.

...

[A62/16 Add.2 – 7 May 2009]

1. Resolution WHA61.21 requested the Director-General, inter alia, to finalize the outstanding components of the plan of action, including progress indicators, and submit them for consideration to the Sixty-second World Health Assembly. A set of progress indicators was presented to the Executive Board at its 124th session and, based on comments received,³ a revised set [was presented in document A62/16 Add.2].

...

[A62/16 Add.3 – 18 May 2009]

As a result of informal consultations among Member States in order to reach agreement on the open paragraphs on stakeholders in the plan of action,⁴ [the final proposals for the remaining specific actions were presented in document A62/16 Add.3].

[The progress indicators are set out by element below. The time frames and finalized paragraphs on stakeholders have been incorporated into the finalized plan of action which is also reproduced below.]

¹ See resolution WHA62.16.

² See resolution WHA61.21, Annex.

³ Document EB124/2009/REC/2, summary record of the tenth meeting.

⁴ Document A62/16, paragraph 12.

PROGRESS INDICATORS

INDICATORS BY ELEMENT

Element 1. Prioritizing research and development needs

Indicators

- analysis of research and development gaps, including the public health consequences of these gaps in developing countries, completed and a report on this analysis produced, published and disseminated
- number of developing countries with national health-related research and development capacity-building plans which prioritize research and development based on identified public health needs and research and development gaps
- number of consensus reports published on global research needs and priorities for a disease or type of intervention.

Element 2. Promoting research and development

Indicators

- number of countries whose national strategic plans for the health workforce and related professionals include a research and development component
- number of new or strengthened national, regional and global coordination initiatives on health-related research and development, including between public and private entities
- number of new or strengthened initiatives aimed at providing efficient and affordable access to publications and information such as research knowledge, results and technology
- number of new or strengthened initiatives aimed at enhancing capacities to analyse and manage clinical trial data
- proportion of peer-reviewed publications where the main author's institution is in a developing country.

Element 3. Building and improving innovative capacity

Indicators

- number of new and existing research centres in developing countries strengthened through comprehensive institutional development and support
- proportion of developing countries in which national health research systems meet international standards
- number of countries whose national regulatory authorities have been assessed, supported and accredited

- number of new or updated global quality and ethical standards, reference preparations, guidelines and tools for promoting the quality and effective regulation of health products¹ and technologies
- number of countries with a national traditional medicines policy that includes research and development.

Element 4. Transfer of technology*Indicators*

- number of national, regional and global coordination and collaboration initiatives aimed at increasing and facilitating transfer of health-related technology, including between public and private entities
- number of countries with technology transfer strategies that include health-related technologies and relevant capacity-building components.

Element 5. Application and management of intellectual property to contribute to innovation and promote public health*Indicators*

- number of countries engaged in initiatives to strengthen capacities to manage and apply intellectual property rights to contribute to innovation and promote public health
- number of countries promoting and supporting efforts to strengthen capacities in the management and application of intellectual property rights in a manner oriented to public health needs and priorities of developing countries
- number of countries integrating flexibilities for protection of public health of the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights into national legislation
- number and type of initiatives between secretariats and governing bodies of relevant regional and international organizations aimed at coordinating work relating to intellectual property and public health.

Element 6. Improving delivery and access*Indicators*

- number of countries formulating and implementing official national policies on access, quality and use of essential medical products and technologies

¹ The term “health products” hereafter should be understood to include vaccines, diagnostics and medicines in accordance with resolution WHA59.24.

- number of countries designing or strengthening comprehensive national procurement and supply systems
- number of priority health products and diagnostic tools that have been assessed and prequalified for procurement by the United Nations
- number of countries possessing and implementing national or regional strategic plans for the health workforce and related professionals, including policies and management practices on incentives, regulation and retention
- number of countries that have an adequate number of qualified or trained health-related regulatory professionals and the specific areas of specialization where gaps exist.

Element 7. Promoting sustainable financing mechanisms

Indicators

- submission of report of expert working group on research and development and financing
- number of new or strengthened sustainable financing initiatives including public–private initiatives
- increase in sustainable health-related research and development funding relevant to the strategy¹ over the reporting period.

Element 8. Establishing monitoring and reporting systems

Indicators

- regular reporting on progress towards the implementation of the strategy²
- number of new or strengthened sustainable initiatives at national, regional and global levels, including those by nongovernmental stakeholders, to promote the implementation of the strategy
- submission of reports on the respective issues addressed in Element 8 of the strategy.

Additional overarching strategic indicators

- number of new and improved health products receiving internationally recognized approval for use, including information on the nature and novelty of these products
- number of new and improved interventions and implementation strategies whose effectiveness has been determined and the evidence made available to appropriate institutions for policy decisions.

¹ Baselines/guidance to be provided by the expert working group on research and development and financing, established in accordance with resolution WHA61.21.

² A qualitative assessment measuring progress on the objectives of the strategy to be included as a key component in the comprehensive four-year evaluation required by paragraph 41 of the Global strategy.

PLAN OF ACTION

Explanatory notes

* **Stakeholder(s)**

Lead stakeholders are indicated by bold typeface.

Reference to **Governments** means that Member States¹ are urged to take action.

WHO means that the Director-General is requested to take action.

Other international intergovernmental organizations, both global and regional, means that Member States, or the WHO Secretariat as mandated by Member States through this plan of action, invite these organizations to take action. Member States are urged to raise appropriate issues in the governing bodies of the organizations. The Director-General is requested to bring this global strategy and plan of action to the attention of all relevant international organizations and invite them to consider the relevant provisions of this global strategy and plan of action.

Other relevant stakeholders means that Member States, or the WHO Secretariat as mandated by its Member States through this plan of action, invite these relevant actors to take action. These include, inter alia, as appropriate, international and national research institutions; academia; national and regional regulatory agencies; relevant health-related industries, including both public and private; public-private partnerships; public-private and product development partnerships; nongovernmental organizations; concerned communities; development partners; charitable foundations; publishers; research and development groups; and regional bodies; and regional organizations.

¹ Where applicable, also regional economic integration organizations.

Elements and sub-elements	Specific actions	Stakeholder(s)*	Time frame
Element 1. Prioritizing research and development needs			
(1.1) mapping global research and development with a view to identifying gaps in research and development on diseases that disproportionately affect developing countries	<p>(a) develop methodologies and mechanisms to identify gaps in research on Type II and Type III diseases and on developing countries' specific research and development needs in relation to Type I diseases</p> <p>(b) disseminate information on identified gaps, and evaluate their consequences on public health</p> <p>(c) provide an assessment of identified gaps at different levels – national, regional and international – to guide research aimed at developing affordable and therapeutically sound products to meet public health needs</p>	<p>WHO; Governments; other relevant stakeholders</p> <p>WHO; Governments; other relevant stakeholders</p> <p>WHO; Governments; other relevant stakeholders</p>	<p>2008–2015</p> <p>2008–2015</p> <p>2008–2015</p>
(1.2) formulating explicit prioritized strategies for research and development at country and regional and interregional levels	<p>(a) set research priorities so as to address public health needs and implement public health policy based on appropriate and regular needs assessments</p> <p>(b) conduct research appropriate for resource-poor settings and research on technologically appropriate products for addressing public health needs to combat diseases in developing countries</p> <p>(c) include research and development needs on health systems in a prioritized strategy</p>	<p>Governments; regional organizations</p> <p>Governments; WHO; other relevant stakeholders (including academia, relevant health-related industries, national research institutions and public-private partnerships)</p> <p>Governments; WHO; other relevant stakeholders (including academia, national</p>	<p>2008–2015</p> <p>2008–2015</p> <p>2008–2015</p>

		research institutions, and public-private partnerships)	2008–2015
	(d) urge the leadership and commitment of governments, regional and international organizations and the private sector in determining priorities for research and development to address public health needs	WHO ; Governments; other international intergovernmental organizations; other relevant stakeholders (including private sector)	
	(e) increase overall research and development efforts on diseases that disproportionately affect developing countries, leading to the development of quality products to address public health needs, that are user friendly (in terms of use, prescription and management) and accessible (in terms of availability and affordability)	Governments ; WHO; other relevant stakeholders (including academia, relevant health-related industries, national research institutions, and public-private partnerships)	2008–2015
	(1.3) encouraging research and development in traditional medicine in accordance with national priorities and legislation, and taking into account the relevant international instruments, including, as appropriate, those concerning traditional knowledge and the rights of indigenous peoples	Governments ; WHO; other international intergovernmental organizations; other relevant stakeholders (including academia; national research institutions; public-private partnerships; and concerned communities)	2008–2015
	(b) support developing countries to build their capacity in research and development in traditional medicine	Governments ; WHO; other international intergovernmental organizations; other relevant stakeholders (including academia, relevant health-related industries, national research institutions, public-private partnerships)	2008–2015

	(c) promote international cooperation and the ethical conduct of research	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders	2008–2015
	(d) support South–South cooperation in information exchange and research activities	Governments; WHO; other international intergovernmental organizations; regional organizations; other relevant stakeholders	2008–2015
	(e) support early-stage drug research and development in traditional medicine systems in developing countries	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders	2008–2015
	Specific actions	Stakeholder(s)*	Time frame
Elements and sub-elements			
Element 2. Promoting research and development			
(2.1) supporting governments to develop or improve national health research programmes and establish, where appropriate, strategic research networks to facilitate better coordination of stakeholders in this area	(a) promote cooperation between private and public sectors on research and development	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders	2008–2015
	(b) provide support for national health research programmes in developing countries through political action and, where feasible and appropriate, long-term funding	Governments; regional organizations; WHO (technical assistance); other relevant stakeholders	2008–2015
	(c) support governments in establishing health-related innovation in developing countries	Governments; regional organizations; WHO (technical assistance); other relevant stakeholders	2008–2015
(2.2) promoting upstream research and product development in developing countries	(a) support discovery science, including, where feasible and appropriate, voluntary open-source methods, in order to develop a sustainable portfolio of new products	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders	2008–2015

	(b) promote and improve accessibility to compound libraries through voluntary means, provide technical support to developing countries and promote access to drug leads identified through the screening of compound libraries	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders	2008–2015
	(c) identify incentives and barriers, including intellectual property-related provisions, at different levels – national, regional and international – that might affect increased research on public health, and suggest ways to facilitate access to research results and research tools	Governments; WHO; other international intergovernmental organizations (including WIPO and WTO); other relevant stakeholders	2008–2015
	(d) support basic and applied scientific research on Type II and Type III diseases and on the specific research and development needs of developing countries in relation to Type I diseases	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders	2008–2015
	(e) support early-stage drug research and development in developing countries	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including relevant health-related industries, academia, international and national research institutions; donor agencies; development partners; nongovernmental organizations)	2008–2015
	(f) build capacity to conduct clinical trials and promote public and other sources of funding for clinical trials	Governments; WHO; other international intergovernmental organizations; other relevant	2008–2015

(2.3) improving cooperation, participation and coordination of health and biomedical research and development	and other mechanisms for stimulating local innovation, taking into account international ethical standards and the needs of developing countries	stakeholders (including relevant health-related industries; academia; development partners; charitable foundations; public-private partnerships; nongovernmental organizations)	
	(g) promote the generation, transfer, acquisition upon agreed terms and voluntary sharing, of new knowledge and technologies, consistent with national law and international agreements, to facilitate the development of new health products and medical devices to tackle the health problems of developing countries	Governments; WHO; other international intergovernmental organizations, other relevant stakeholders (including; academia, international and national research institutions; relevant health-related industries and development partners)	2008–2015
	(a) stimulate and improve global cooperation and coordination in research and development, in order to optimize resources	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders	2008–2015
	(b) enhance existing fora and examine the need for new mechanisms, in order to improve the coordination and sharing of information on research and development activities	Governments; WHO; other relevant stakeholders	2008–2015
	(c) encourage further exploratory discussions on the utility of possible instruments or mechanisms for essential health and biomedical research and development, including inter alia, an essential health and	Governments; other relevant stakeholders (including nongovernmental organizations)	2008–2010

(2.4) promoting greater access to knowledge and technology relevant to meet public health needs of developing countries	biomedical research and development treaty		
	(d) support active participation of developing countries in building technological capacity	Governments; WHO; other relevant stakeholders	2008–2015
	(e) promote the active participation of developing countries in the innovation process	Governments; WHO; other relevant stakeholders	2008–2015
	(a) promote the creation and development of accessible public health libraries in order to enhance availability and use of relevant publications by universities, institutes and technical centres, especially in developing countries	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including academia, research institutions, relevant health-related industries; nongovernmental organizations; publishers)	2008–2015
	(b) promote public access to the results of government-funded research, by strongly encouraging all investigators funded by governments to submit to an open access database an electronic version of their final, peer-reviewed manuscripts	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including academia and research institutions)	2008–2015
	(c) support the creation of voluntary open databases and compound libraries including voluntary provision of access to drug leads identified through the screening of such compound libraries	Governments; WHO; other international intergovernmental organizations (including WIPO); other relevant stakeholders (including relevant health-related industries)	2008–2015
	(d) encourage the further development and dissemination of publicly or donor-funded medical	Governments; WHO; other international intergovernmental organizations; other relevant	2008–2015

	inventions and know-how through appropriate licensing policies, including but not limited to open licensing, that enhance access to innovations for development of products of relevance to the public health needs of developing countries on reasonable, affordable and non-discriminatory terms	stakeholders (including academia and national research institutions)	
	(e) consider, where appropriate, use of a “research exception” to address public health needs in developing countries consistent with the Agreement on Trade-Related Aspects of Intellectual Property Rights	Governments	2008–2015
2.5 establishing and strengthening national and regional coordinating bodies on research and development	(a) develop and coordinate a research and development agenda	Governments; regional organizations; WHO; other relevant stakeholders	2008–2015
	(b) facilitate the dissemination and use of research and development outcomes	Governments; regional organizations; WHO; other relevant stakeholders	2008–2015
Elements and sub-elements	Specific actions	Stakeholder(s)*	Time frame
Element 3. Building and improving innovative capacity			
(3.1) building capacity of developing countries to meet research and development needs for health products	(a) support investment by developing countries in human resources and knowledge bases, especially in education and training including in public health	Governments; other international intergovernmental organizations; other relevant stakeholders (including development partners)	2008–2015
	(b) support existing and new research and development groups and institutions, including regional centres of excellence, in developing countries	Governments; other international intergovernmental organizations; other relevant stakeholders	2008–2015

	(including research and development groups, relevant health-related industries and development partners)		
	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including nongovernmental organizations, research institutions, academia)	2008–2015	
(3.2) framing, developing and supporting effective policies that promote the development of capacities for health innovation	(a) establish and strengthen regulatory capacity in developing countries	Governments; WHO; other relevant stakeholders (including national and regional regulatory agencies)	2008–2015
	(b) strengthen human resources in research and development in developing countries through long-term national capacity-building plans	Governments; other international intergovernmental organizations; other relevant stakeholders (including development partners; international and national research institutions)	2008–2015
	(c) encourage international cooperation to develop effective policies for retention of health professionals including researchers in developing countries	Governments; WHO; other international intergovernmental organizations (including IOM and ILO); other relevant stakeholders	2008–2015
	(d) urge Member States to establish mechanisms to mitigate the adverse impact of the loss of health personnel in developing countries, particularly researchers, through migration, including by ways for both receiving and originating	Governments	2008–2015

	countries to support the strengthening of national health and research systems, in particular human resource development in the countries of origin, taking into account the work of WHO and other relevant organizations		
(3.3) providing support for improving innovative capacity in accordance with the needs of developing countries	(a) develop successful health innovation models in developing innovative capacity	Governments; WHO; other international intergovernmental organizations (including WIPO, OECD and UNCTAD); other relevant stakeholders (including academia; research institutions; health-related industries and developmental partners)	2008–2015
	(b) intensify North–South and South–South partnerships and networks to support capacity building	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including academia, research institutions, relevant health-related industries)	2008–2015
	(c) establish and strengthen mechanisms for ethical review in the research and development process, including clinical trials, especially in developing countries	Governments; WHO; other relevant stakeholders (including academia and research institutions)	2008–2015
(3.4) supporting policies that will promote innovation based on traditional medicine within an evidence-based framework in accordance with national priorities and taking into account the relevant provisions of relevant international instruments	(a) establish and strengthen national and regional policies to develop, support and promote traditional medicine	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including concerned communities)	2008–2015

	(b) encourage and promote policies on innovation in the field of traditional medicine	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including international and national research institutions, concerned communities)	2008–2015
	(c) promote standard setting to ensure the quality, safety and efficacy of traditional medicine, including by funding the research necessary to establish such standards	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including national and regional regulatory agencies; international and national research institutions; development partners; concerned communities)	2008–2015
	(d) encourage research on mechanisms for action and pharmacokinetics of traditional medicine	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including academia; international and national research institutions; relevant health-related industries; concerned communities)	2008–2015
	(e) promote South–South collaboration in traditional medicine	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including research institutions, regional bodies, academia)	2008–2015
	(f) formulate and disseminate guidelines on good manufacturing practices for traditional medicines	Governments; WHO; other international intergovernmental organizations; other relevant	2008–2015

	and laying down evidence-based standards for quality and safety evaluation	stakeholders (including national and regional regulatory agencies, relevant health-related industries)	
(3.5) developing and implementing, where appropriate, possible incentive schemes for health-related innovation	(a) encourage the establishment of award schemes for health-related innovation	Governments; WHO; other international intergovernmental organizations (including WIPO); other relevant stakeholders (including academia; international and national research institutions; development partners; charitable foundations)	2008–2015
	(b) encourage recognition of innovation for purposes of career advancement for health researchers	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including academia; international and national research institutions; development partners; charitable foundations)	2008–2015
Elements and sub-elements			
Element 4. Transfer of technology			
(4.1) promoting transfer of technology and the production of health products in developing countries	(a) explore possible new mechanisms and make better use of existing mechanisms to facilitate transfer of technology and technical support to build and improve innovative capacity for health-related research and development, particularly in developing countries	Governments; WHO; other international intergovernmental organizations (including WIPO, WTO, UNCTAD, UNIDO); other relevant stakeholders (including international and national research institutions; relevant health-related industries)	2008–2015

	(b) promote transfer of technology and production of health products in developing countries through investment and capacity building	Governments; WHO; other intergovernmental organizations; other relevant stakeholders (including health-related industries)	2008–2015
	(c) promote transfer of technology and production of health products in developing countries through identification of best practices, and investment and capacity building provided by developed and developing countries where appropriate	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including relevant health-related industries ; academia; nongovernmental organizations; development partners; charitable foundations)	2008–2015
(4.2) supporting improved collaboration and coordination of technology transfer for health products, bearing in mind different levels of development	(a) encourage North–South and South–South cooperation for technology transfers, and collaboration between institutions in developing countries and the pharmaceutical industry	Governments; WHO; other international intergovernmental organizations (including WIPO); other relevant stakeholders (including relevant health-related industries; international and national research institutions; academia; nongovernmental organizations; development partners)	2008–2015
	(b) facilitate local and regional networks for collaboration on research and development and transfer of technology	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including relevant health-related industries, national research institutions, academia; nongovernmental organizations)	2008–2015

	(c) continue to promote and encourage technology transfer to least-developed country members of the WTO consistent with Article 66.2 of the Agreement on Trade-Related Aspects of Intellectual Property Rights	Governments	2008–2015
	(d) promote the necessary training to increase absorptive capacity for technology transfer	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including research institutions)	2008–2015
(4.3) developing possible new mechanisms to promote transfer of and access to key health-related technologies	(a) examine the feasibility of voluntary patent pools of upstream and downstream technologies to promote innovation of and access to health products and medical devices	Governments; WHO; other international intergovernmental organizations (including WIPO); other relevant stakeholders (including international and national research institutions; relevant health-related industries, nongovernmental organizations; academia)	2008–2015
	(b) explore and, if feasible, develop possible new mechanisms to promote transfer of and access to key health-related technologies of relevance to public health needs of developing countries especially on Type II and III diseases and the specific research and development needs of developing countries in respect of Type I diseases, which are consistent with the provisions of the	Governments; WHO; other international intergovernmental organizations (including WIPO, WTO); other relevant stakeholders (including health-related industries)	2008–2015

<p>Agreement on Trade-Related Aspects of Intellectual Property Rights and instruments related to that Agreement, which provide flexibilities to take measures to protect public health</p>	<p>Stakeholder(s)*</p>	<p>Time frame</p>
<p>Elements and sub-elements</p>		
<p>Element 5. Application and Management of intellectual property to contribute to innovation and promote public health</p>		
<p>(5.1) support information sharing and capacity building in the application and management of intellectual property with respect to health-related innovation and the promotion of public health in developing countries</p>	<p>(a) encourage and support the application and management of intellectual property in a manner that maximizes health-related innovation and promotes access to health products and that is consistent with the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights and other WTO instruments related to that Agreement and meets the specific research and development needs of developing countries</p>	<p>Governments; WHO; other international intergovernmental organizations (including WIPO, WTO, UNCTAD); other relevant stakeholders (including international and national research institutions and development partners)</p>
	<p>(b) promote and support, including through international cooperation, national and regional institutions in their efforts to build and strengthen capacity to manage and apply intellectual property in a manner oriented to public health needs and priorities of developing countries</p>	<p>Governments; WHO; other international intergovernmental organizations (including WIPO, WTO, UNCTAD); other relevant stakeholders (including international and national research institutions and development partners)</p>

<p>(c) facilitate widespread access to, and promote further development of, including, if necessary, compiling, maintaining and updating, user-friendly global databases which contain public information on the administrative status of health-related patents, including supporting the existing efforts for determining the patent status of health products, in order to strengthen national capacities for analysis of the information contained in those databases, and improve the quality of patents</p>	<p>Governments; WHO; other international intergovernmental organizations (including WIPO, WTO, UNCTAD); other relevant stakeholders (including international and national research institutions and development partners)</p>	<p>2008–2015</p>
<p>(d) stimulate collaboration among pertinent national institutions and relevant government departments, as well as between national, regional and international institutions, in order to promote information sharing relevant to public health needs</p>	<p>Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including academia; international and national research institutions; development agencies; nongovernmental organizations; relevant health-related industries)</p>	<p>2008–2015</p>
<p>(e) strengthen education and training in the application and management of intellectual property, from a public health perspective taking into account the provisions contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights, including the flexibilities</p>	<p>Governments; WHO; other international intergovernmental organizations (including WIPO, WTO, UNCTAD); other relevant stakeholders (including international and national research institutions and development partners)</p>	<p>2008–2015</p>

	recognized by the Doha Declaration on the TRIPS Agreement and Public Health and other WTO instruments related to the TRIPS agreement		
	(f) facilitate, where feasible and appropriate, possible access to traditional medicinal knowledge information for use as prior art in examination of patents, including, where appropriate, the inclusion of traditional medicinal knowledge information in digital libraries	Governments; concerned communities	2008–2015
	(g) promote active and effective participation of health representatives in intellectual property-related negotiations, where appropriate, in order that such negotiations also reflect public health needs	Governments	2008–2015
	(h) strengthen efforts to effectively coordinate work relating to intellectual property and public health among the Secretariats and governing bodies of relevant regional and international organizations in order to facilitate dialogue and dissemination of information to countries	Governments; WHO; other international intergovernmental organizations (including WIPO, WTO, and UNCTAD)	2008–2015
(5.2) providing as appropriate, upon request, in collaboration with other competent international organizations technical support, including, where appropriate, to policy processes, to countries that intend to make use of the provisions contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights, including the flexibilities recognized by the Doha Declaration on the TRIPS Agreement and Public Health and	(a) 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, including those recognized by the	Governments; WHO; other international intergovernmental organizations (including WIPO, WTO and UNCTAD)	2008–2015

other WTO instruments related to the TRIPS agreement, in order to promote access to pharmaceutical products	Doha Declaration on the TRIPS Agreement and Public Health and the WTO decision of 30 August 2003			
	(b) take into account, where appropriate, the impact on public health when considering adopting or implementing more extensive intellectual property protection than is required by the Agreement on Trade-Related Aspects of Intellectual Property Rights, without prejudice to the sovereign rights of Member States	Governments ; WHO; other international intergovernmental organizations (including WIPO, WTO and UNCTAD)	2008–2015	
	(c) take into account in trade agreements the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights and including those recognized by the Doha Declaration on the TRIPS Agreement and Public Health and the WTO decision of 30 August 2003	Governments	2008–2015	
	(d) consider, where appropriate, taking necessary measures in countries with manufacturing capacity to facilitate through export access to pharmaceutical products in countries with insufficient or no manufacturing capacity in the pharmaceutical sector in a manner consistent with the Agreement on Trade-Related Aspects of	Governments	2008–2015	

	Intellectual Property Rights, the Doha Declaration on the TRIPS Agreement and Public Health and the WTO decision of 30 August 2003		
	(e) encourage finding ways, in ongoing discussions, to prevent misappropriation of health-related traditional knowledge, and consider where appropriate, legislative and other measures to help prevent misappropriation of such traditional knowledge	Governments; WHO; other international intergovernmental organizations (including WIPO, WTO, UNEP/Secretariat of the Convention on Biological Diversity); other relevant stakeholders (including concerned communities)	2008–2015
(5.3) exploring and, where appropriate, promoting possible incentive schemes for research and development on Type II and Type III diseases and on developing countries' specific research and development needs in relation to Type I diseases	(a) explore and, where appropriate, promote a range of incentive schemes for research and development including addressing, where appropriate, the de-linkage of the costs of research and development and the price of health products, for example through the award of prizes, with the objective of addressing diseases which disproportionately affect developing countries	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including international and national research institutions; development partners; charitable foundations; relevant health-related industries; nongovernmental organizations)	2008–2015
Elements and sub-elements		Stakeholder(s)*	Time frame
Element 6. Improving delivery and access			
(6.1) encouraging increased investment in the health-delivery infrastructure and financing of health products in order to strengthen the health system	(a) invest in developing health-delivery infrastructure and encourage financing of health products	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including development partners, charitable foundations, private	2008–2015

	sector and relevant health-related industries)	
(b) develop effective and sustainable mechanisms in least-developed countries in order to improve access to existing medicines, acknowledging the transitional period until 2016 ¹	Governments; WHO; other international intergovernmental organizations (including WTO); other relevant stakeholders	2008–2015
(c) prioritize health care in national agendas	Governments	2008–2015
(d) encourage health authorities to improve domestic management capacities in order to improve delivery and access to medicines and other health products with quality, efficacy, safety and affordability and, where appropriate, to develop strategies to promote rational use of medicines	Governments; WHO	2008–2015
(e) increase investment in human resource development in the health sector	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including development partners; nongovernmental organizations; charitable foundations)	2008–2015
(f) develop effective country poverty-reduction strategies that contain clear health objectives	Governments; other relevant stakeholders (including development partners)	2008–2015

¹ In line with the extension, provided to least-developed countries, by Article 7 of the Doha Declaration on the TRIPS Agreement and Public Health.

	(g) encourage pooled procurement mechanisms for health products and medical devices, where appropriate	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders	2008–2015
(6.2) establishing and strengthening mechanisms to improve ethical review and regulate the quality, safety and efficacy of health products and medical devices	(a) develop and/or strengthen the capacity of national regulatory authorities to monitor the quality, safety and efficacy of health products while sustaining ethical review standards	Governments; WHO; other relevant stakeholders (including national and regional regulatory agencies and development partners)	2008–2015
	(b) promote operational research to maximize the appropriate use of new and existing products, including cost-effective and affordable products in high disease-burden settings	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including international and national research institutions; nongovernmental organizations, development partners and charitable foundations)	2008–2015
	(c) comply with good manufacturing practices for safety standards, efficacy and quality of health products	Governments; WHO; other relevant stakeholders (including national regulatory bodies; relevant health-related industries; development partners)	2008–2015
	(d) strengthen the WHO pre-qualification programme	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including development partners)	2008–2015
	(e) where appropriate, initiate programmed actions on regional and sub-regional levels with the ultimate goal of harmonization of processes employed by the regulatory	Governments; WHO; other relevant stakeholders (including national and regional regulatory agencies, regional bodies and	2008–2015

	authorities for drug marketing approvals	development partners)	
	(f) promote ethical principles for clinical trials involving human beings as a requirement of registration of medicines and health-related technologies, with reference to the Declaration of Helsinki, and other appropriate texts, on ethical principles for medical research involving human subjects, including good clinical practice guidelines	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including national and regional regulatory agencies)	2008–2015
	(g) support regional networks and collaborative efforts to strengthen the regulation and implementation of clinical trials using appropriate standards for medicines evaluation and approval	Governments; WHO; other relevant stakeholders (including national and regional regulatory agencies, international and national research institutions, regional bodies and development partners)	2008–2015
(6.3) promoting competition to improve availability and affordability of health products consistent with public health policies and needs	(a) support the production and introduction of generic versions, in particular of essential medicines, in developing countries, through the development of national legislation and/or policies that encourage generic production and entry, including a “regulatory exception” or “Bolar”-type provision, and which are consistent with the Agreement on Trade-Related Aspects of Intellectual Property Rights and instruments related to that agreement	Governments	2008–2015

	(b) frame and implement policies to improve access to safe and effective health products, especially essential medicines, at affordable prices, consistent with international agreements	Governments; WHO; other international intergovernmental organizations (including WTO and WIPO); other relevant stakeholders	2008–2015
	(c) consider where appropriate, inter alia, the reduction or elimination of import tariffs on health products and medical devices and the monitoring of supply and distribution chains and procurement practices to minimize cost and increase access	Governments	2008–2015
	(d) encourage pharmaceutical companies and other health-related industries to consider policies, including differential pricing policies, that are conducive to promoting access to quality, safe, efficacious and affordable health products in developing countries, consistent with national law	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including relevant health-related industries)	2008–2015
	(e) consider, where appropriate, the development of policies to monitor pricing and to improve affordability of health products; further support WHO's ongoing work on pharmaceutical pricing	Governments	2008–2015
	(f) consider, where necessary, and provided that they are consistent with the provisions of the Agreement on Trade-Related Aspects of Intellectual Property Rights, taking appropriate measures to prevent the abuse of intellectual property rights by right holders or	Governments	2008–2015

	the resort to practices which unreasonably restrain trade or adversely affect the international transfer of technology, in the field of health products		
	(g) increase information among policy makers, users, doctors and pharmacists regarding generic products	Governments; WHO other relevant stakeholders (including nongovernmental organizations and relevant health-related industry)	2008–2015
	Specific actions	Stakeholder(s)*	Time frame
Element 7. Promoting sustainable financing mechanisms			
(7.1) endeavouring to secure adequate and sustainable financing for research and development, and improve coordination of its use, where feasible and appropriate, in order to address the health needs of developing countries	(a) establish a results-oriented and time-limited expert working group under the auspices of WHO and linking up with other relevant groups to examine current financing and coordination of research and development, as well as proposals for new and innovative sources of financing to stimulate research and development related to Type II and Type III diseases and the specific research and development needs of developing countries in relation to Type I diseases	Governments; WHO ; other international intergovernmental organizations; other relevant stakeholders	2008–2010
	(b) consider channelling additional funds to health-oriented research organizations as appropriate in both the private and public sector of developing countries and promote good financial management to maximize its effectiveness as recommended by resolution WHA58.34	Governments; WHO ; other international intergovernmental organizations; other relevant stakeholders (including development partners, charitable foundations, international and national research institutions, academia, private sector and relevant health-related industries)	2008–2015

(7.2) facilitating the maximum use of, and complementing as appropriate, existing financing, including that through public-private and product development partnerships, in order to develop and deliver safe, effective and affordable health products and medical devices	(c) create a database of possible sources of financing for research and development	Governments; WHO; other relevant stakeholders	2008–2015
	(a) document and disseminate best practices in public-private and product development partnerships	Governments; WHO ; other relevant stakeholders (including research institutions, public-private and product development partnerships)	2008–2015
	(b) develop tools for periodic assessment of performance of public-private and product development partnerships	Governments; WHO ; other relevant stakeholders (including research institutions; public-private and product development partnerships; charitable foundations)	2008–2009
	(c) support public-private and product development partnerships and other appropriate research and development initiatives in developing countries	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including relevant health-related industries, charitable foundations, development partners, nongovernmental organizations; academia; research institutions)	2008–2015
Elements and sub-elements	Specific actions	Stakeholder(s)*	Time frame
Element 8. Establishing monitoring and reporting systems			
(8.1) measuring performance and progress towards objectives contained in the strategy and plan of action	(a) establish systems to monitor performance and progress of the implementation of each element of the global strategy and plan of action	Governments; WHO	2009–2015
	(b) monitor and report periodically to WHO's governing bodies on the gaps and needs related to health products and medical devices in developed and developing countries	Governments; WHO	2009–2015

	(c) to continue to monitor, from a public health perspective, in consultation as appropriate with other international organizations, the impact of intellectual property rights and other issues addressed in the Report of the Commission on Intellectual Property Rights, Innovation and Public Health, on the development of, and access to, health care products, and to report thereon to the Health Assembly	Governments; WHO ; other international intergovernmental organizations (including WIPO and WTO); other relevant stakeholders	2009–2015
	(d) monitor and report on the impact of incentive mechanisms on innovation of and access to health products and medical devices	Governments; WHO ; other international intergovernmental organizations (including WIPO and WTO); other relevant stakeholders	2009–2015
	(e) monitor and report on investment in research and development to address the health needs of developing countries	Governments; WHO ; other relevant stakeholders	2009–2015

(Eighth plenary meeting, 24 May 2008 –
Committee A, fifth report)

ANNEX 5

Financial and administrative implications for the Secretariat of resolutions adopted by the Health Assembly

1. Resolution WHA62.1 Prevention of avoidable blindness and visual impairment	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected result:
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment.	<p>3.1 Advocacy and support provided to increase political, financial and technical commitment in Member States in order to tackle chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities and visual impairment, including blindness.</p> <p>3.2 Guidance and support provided to Member States for the development and implementation of policies, strategies and regulations in respect of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities and visual impairment, including blindness.</p> <p>3.3 Improvements made in Member States' capacity to collect, analyse, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities and visual impairment, including blindness.</p> <p>3.4 Improved evidence compiled by WHO on the cost-effectiveness of interventions to tackle chronic noncommunicable diseases, mental and neurological and substance-use disorders, violence, injuries and disabilities and visual impairment, including blindness.</p> <p>3.5 Guidance and support provided to Member States for the preparation and implementation of multisectoral, population-wide programmes to promote mental health and to prevent mental and neurological disorders, violence and injuries, together with hearing and visual impairment, including blindness.</p> <p>3.6 Guidance and support provided to Member States to improve the ability of their health and social systems to prevent and manage chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities and impairment, including blindness.</p>

<p align="center">(Briefly indicate the linkage with expected results, indicators, targets, baseline)</p> <p>The resolution and the draft action plan are consistent with the expected results. Three indicators exist: 3.2.5, 3.3.5 and 3.5.3. Additional indicators will be designed as needed.</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)</p> <p>US\$ 14.2 million is needed for the implementation of the action plan.</p> <p>(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)</p> <p>Total costs are estimated at US\$ 925 000 for the remaining six months of the biennium.</p> <p>(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009?</p> <p>US\$ 320 000 is available for the remaining for period of the biennium 2008–2009. This implies the need for an additional provision of US\$ 600 000.</p> <p>(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)</p> <p>Additional funding from international partners is expected through active resource mobilization.</p>	
<p>4. Administrative implications</p> <p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)</p> <p>Currently most activities are performed at headquarters and in the regional offices for Africa, the Americas and the Eastern Mediterranean. Additional positions would need to be established in the regional offices for Europe, South-East Asia and the Western Pacific.</p> <p>(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile)</p> <p>At headquarters, one additional full-time equivalent will be required in the professional category together with one staff member in the general service category. One full-time position in the professional category and one full-time position in the general service category will be required in the regional offices for Europe, South-East Asia and the Western Pacific.</p> <p>(c) Time frames (indicate broad time frames for implementation)</p> <p>Remaining five years of the Medium-term strategic plan, namely 2009 to 2013.</p>	
<p>1. Resolution WHA62.2 Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan</p>	
<p>2. Linkage to programme budget</p> <p>Strategic objective:</p> <p>5. To reduce the health consequences of emergencies, disasters, crises and conflicts and minimize their social and economic impact.</p>	<p>Organization-wide expected result:</p> <p>5.3 Norms and standards developed and capacity built to enable Member States to assess needs and for planning interventions during the transition and recovery phases of conflicts and disasters.</p>

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

If fully funded and implemented, the resolution is expected to have an impact on the targets for the second and third indicators for this 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)

US\$ 3 970 000 over the one-year period of the resolution, including staff, travel, training activities, technical assistance, health supplies, security and operational equipment.

A substantial proportion of these resources have been raised as humanitarian voluntary contributions for addressing humanitarian health needs, implementing life-saving interventions, re-establishing the functionality of the disrupted health services and rolling out the Interagency Standing Committee health cluster.

The breakdown of the estimated cost of operative paragraph 4 is as follows:

Subparagraph (1)	US\$ 100 000
Subparagraph (2)	US\$ 70 000
Subparagraph (3)	US\$ 50 000
Subparagraph (4)	US\$ 200 000
Subparagraph (5)	US\$ 500 000
Subparagraph (6)	US\$ 3 000 000
Subparagraph (7)	US\$ 50 000
Total	US\$ 3 970 000

(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities)

US\$ 3 970 000 (one year life-cycle).

(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009? Seventy-five per cent of US\$ 3 970 000 at headquarters, Regional and Jerusalem Office levels.

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

Not applicable.

4. Administrative implications

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

The activities will be primarily implemented through the WHO Office in Jerusalem, responsible for WHO's cooperation programme with the Palestine Authority. WHO's country-level efforts will be supplemented by support from the Regional Office for the Eastern Mediterranean, and by the headquarters clusters working in the areas of health action in crises, health security and environment.

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

It will be necessary to sustain beyond May 2009 the presence at country level of the national and international staff recruited to implement humanitarian health activities and interventions in the occupied Palestinian territory.

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

One year.

1. Resolution WHA62.12 Primary health care, including health system strengthening

2. Linkage to programme budget

Strategic objective:

Strategic objectives 1–11 (all technical objectives).

Organization-wide expected result:

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

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

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

3. Financial implications

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

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

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

Biennium	Task	Estimated cost (US\$ thousands)
2008–2009	• Organizational alignment and capacity building	800
	• Cross-cutting strategic initiatives	1 000
	• Country support and exchange	100
2010–2011	• Organizational alignment and capacity building	500
	• Cross-cutting strategic initiatives	500
	• Country support and exchange	1 000
2012–2013	• Organizational alignment and capacity building	100
	• Cross-cutting strategic initiatives	300
	• Country support and exchange	600

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

US\$ 1.9 million (see note above).

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

50%, or US\$ 950 000.

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

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

4. Administrative implications

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

All levels of the Organization will be involved.

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

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

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

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

1. Resolution WHA62.15 Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis

2. Linkage to programme budget

Strategic objective:

2. To combat HIV/AIDS, tuberculosis and malaria

Organization-wide expected result:

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

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

treatment services, respiratory care, neglected diseases and environmental health.

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

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

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

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

The resolution builds on the Stop TB strategy, the Stop TB Partnership's Global Plan to Stop TB, 2006–2015, resolutions WHA58.14 and WHA60.19, and the Beijing Call for Action on tuberculosis control and patient care. It provides a framework for achieving the array of expected results, targets and baseline figures in respect of tuberculosis control outlined in strategic objective 2 for the Medium-term Strategic Plan 2008–2013. Furthermore, it is aligned with the expected results and indicators included in the workplan for tuberculosis for the biennium 2008–2009.

3. Financial implications

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

The life-cycle of the resolution covers the period 2009–2015. The estimated cost for the Secretariat's implementation responsibilities – including actions at WHO headquarters, in all regional offices and in relevant country offices – is US\$ 175 million.

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

For the remainder of the biennium, a total of US\$ 11.5 million is needed, of which US\$ 6 million is for the regional offices and relevant country offices. In order to fulfil WHO's responsibilities as outlined in the resolution, US\$ 50 million will be required for the biennium 2010–2011 at headquarters and regional offices and in country offices in all countries with a high burden of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis.

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

Of the total of US\$ 11.5 million, US\$ 5.2 million can be subsumed under existing programmed activities in this biennium.

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

Additional funding from a range of partners will be sought through active resource mobilization, building on strong existing partnerships, including those with the Global Fund to Fight AIDS, Tuberculosis and Malaria, the International Drug Purchase Facility (UNITAID), and several bilateral agencies and foundations.

4. Administrative implications

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

Multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis pose a major threat in all regions; intensifying the response will require action at headquarters, the regional offices and in country offices in at least the 27 countries on which multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis place the heaviest burden.

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

Additional positions will need to be established in the regional offices for Africa, the Americas, South-East Asia, the Eastern Mediterranean and the Western Pacific.

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

The period 2009–2015, with interim annual and biennial reports on progress.

1. Resolution WHA62.16 Global strategy and plan of action on public health, innovation and intellectual property

2. Linkage to programme budget

Strategic objective:

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

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

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

Organization-wide expected result:

1.5 New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases developed and validated, with scientists from developing countries increasingly taking the lead in this research.

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

10.5 Better knowledge and evidence for health decision-making assured through consolidation and publication of existing evidence, facilitation of knowledge generation in priority areas, and global leadership in health research policy and coordination, including with regard to ethical conduct.

10.6 National health research for development of health systems strengthened in the context of regional and

<p>11. To ensure improved access, quality and use of medical products and technologies.</p> <p>12. To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work.</p> <p>(Briefly indicate the linkage with expected results, indicators, targets, baseline)</p> <p>The resolution builds on resolution WHA61.21 and is consistent with the above-mentioned strategic objectives and Organization-wide expected results of the Programme budget 2008–2009 and the Medium-term strategic plan 2008–2013.</p>	<p>international research and engagement of civil society.</p> <p>11.1 Formulation and monitoring of comprehensive national policies on access, quality and use of essential medical products and technologies advocated and supported.</p> <p>11.2 International norms, standards and guidelines for the quality, safety, efficacy and cost-effective use of medical products and technologies developed and their national and/or regional implementation advocated and supported.</p> <p>12.3 Global health and development mechanisms established to provide more sustained and predictable technical and financial resources for health on the basis of a common health agenda which responds to the health needs and priorities of Member States.</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)</p> <p>WHO has the role of lead or co-lead stakeholder and implementing entity in almost half the 106 specific actions of the plan of action and is identified as stakeholder/implementing entity in a number of other specific actions. Based on the estimated funding needs outlined in document A62/16 Add.1, the financial and administrative implications of implementing the global strategy and plan of action by WHO (involving the relevant departments at headquarters and regional and country offices) over the envisaged seven-year period (2009–2015) are estimated at US\$ 350 million. It is further estimated that 40% of this amount can be subsumed within existing and future budget.</p> <p>(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)</p> <p>Costs are estimated at US\$ 15 million.</p> <p>(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009? US\$ 7 million.</p> <p>(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)</p> <p>Financing will be sought from interested Member States, development partners, charitable foundations and other donors.</p>	
<p>4. Administrative implications</p> <p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)</p> <p>In the biennium 2008–2009, work will be largely performed at headquarters and in the regional offices.</p>	

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

In order to implement the global strategy, six additional staff in the professional category and four additional staff in the general service category will be required at headquarters. In addition, two additional staff in the professional category and one staff member in the general service category will be required in each regional office.

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

This report covers implementation of the plan of action in the biennium 2008–2009 and the following three bienniums. The plan of action adopted by the Sixty-second World Health Assembly defines time frames for implementation of the global strategy over the full life-cycle. The global strategy requires a progress report to be submitted to the Health Assembly through the Executive Board every two years, and a comprehensive evaluation of the strategy to be undertaken after four years.
