

ANNEXES

ANNEX 1

Policy on WHO engagement with global health partnerships and hosting arrangements¹

[A63/44, Annex – 22 April 2010
and A63/44 Corr.1 – 13 May 2010]

1. This document presents WHO's policy that provides a framework to guide WHO's assessment of, and decision concerning, potential engagement in different types of health partnerships; it also provides specific parameters to be applied in cases where WHO agrees to host a formal partnership.
2. The set of criteria noted below aims to guide WHO's decision making about when and how to engage in partnerships, and how to develop, revise or terminate that engagement. WHO favours, as a general principle, mechanisms within WHO that facilitate collaboration without involving separate governance structures.
3. The number of global health partnerships, initiatives and other forms of collaboration has increased steadily over the past decade. The term "partnerships" is being used generically to include various organizational structures, relationships and arrangements within and external to WHO for furthering collaboration in order to achieve better health outcomes. These range from legally incorporated entities with their own governance to simpler collaborations with varied stakeholders. Diverse terms such as "partnership", "alliance", "network", "programme", "project collaboration", "joint campaigns," and "task force" may be used in the title of these partnerships, although this list does not represent a typology.
4. Examples of different partnerships include legally incorporated entities external to WHO (e.g., Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance, the Medicines for Malaria Venture) and unincorporated partnerships within WHO with their own governance (e.g., Stop TB Partnership, Partnership for Maternal, Newborn and Child Health, Roll-Back Malaria Partnership, UNAIDS, the Global Health Workforce Alliance, and the Health Metrics Network).
5. As part of its core functions, WHO manages several collaborative efforts that are fully under its managerial control and accountability and for which there are no separate governance arrangements, and are designed to provide a means to collaborate with multiple stakeholders. Examples include networks, programmes, task forces and project collaborations such as the Global Outbreak and Response Network, Global Noncommunicable Disease Network, Guinea Worm Eradication Program, Meningitis Vaccine Project, Global Polio Eradication Initiative, and the Global Task Force on Cholera Control.

Definition

6. For the purposes of this policy, the term "formal partnerships" refers to those partnerships with or without a separate legal personality but with a governance structure (for example, a board or steering committee) that takes decisions on direction, workplans and budgets. WHO currently serves as the host organization for several formal partnerships which have not been established as legal

¹ See resolution WHA63.10.

entities. WHO's decision-making process for engaging in partnerships, outlined below, applies in all cases whether or not the partnership is external to the Organization.

Criteria for WHO's engagement in a partnership

7. In all situations in which the Secretariat identifies a need for, or is asked to participate in, a partnership it will use a decision tree (see Appendix) based on the criteria below to review such requests and identify alternatives as necessary. This process applies to all forms of partnership regardless of whether WHO is hosting it, or those not hosted by WHO in which WHO seeks, or is asked, to serve as a partner at a technical level.

8. The following criteria will be used to assess future partnerships and will guide the relationship with the existing formal partnerships.

(a) **The partnership demonstrates a clear added value for public health** in terms of mobilizing partners, knowledge and resources, and creating synergy, in order to achieve a public-health goal that would otherwise not be met to the same extent.

(b) **The partnership has a clear goal that concerns a priority area of work for WHO** reflected in WHO's strategic objectives, and for which realistic time frames are provided. Participation would represent an extension of WHO's core functions, policies, and relative strengths to other organizations, and would reinforce the quality and integrity of WHO's programmes and work.

(c) **Partnerships are guided by the technical norms and standards** established by WHO.

(d) **The partnership supports national development objectives.** In cases where a partnership is active at country level and seeks to help to build capacity in-country, WHO's engagement would help to harmonize efforts and thus reduce the overall management burden on countries.

(e) **The partnership ensures appropriate and adequate participation of stakeholders.** The agreed goals of the partnership shall be ensured through the active participation of all relevant stakeholders (including, as relevant, beneficiaries, civil society and the private sector) and the respect of their individual mandates. Partnerships may benefit from the contribution of organizations and agencies outside the traditional public-health sector as relevant.

(f) **The roles of partners are clear.** In order for WHO to participate in a partnership, the latter must clearly articulate the strengths of the partners, avoid duplication of WHO's and partners' activities, and the introduction of parallel systems.

(g) **Transaction costs related to a partnership must be evaluated, along with the potential benefits and risks.** Expected additional workloads for WHO (at all levels) shall be assessed and quantified.

(h) **Pursuit of the public-health goal takes precedence over the special interests of participants.** Risks and responsibilities arising from public-private partnerships need to be identified and managed through development and implementation of safeguards that incorporate considerations of conflicts of interest. The partnership shall have mechanisms to identify and manage conflicts of interest. Whenever commercial, for-profit companies are considered as potential partners, potential conflicts of interest shall be taken into consideration as part of the design and structure of the partnership.

(i) **The structure of the partnership corresponds to the proposed functions.** The design of the structure of the partnership should correspond to its function. For example, those with a significant financing element may require a more formal governance structure, with clear accountability for funding decisions. Those whose role is primarily a coordinating one could most effectively operate without a formal governance structure. Task-focused networks can be highly effective and efficient in achieving partnership goals with maximum flexibility, and can limit the transaction costs often associated with formal structures and governance mechanisms.

(j) **The partnership has an independent external evaluation and/or self-monitoring mechanism.** The time frame, purpose, objectives, structure and functioning of a partnership shall be regularly reviewed and modified as appropriate. Criteria for modifying or ending a partnership shall be clearly presented, along with consideration for transition plans.

Hosting arrangements

9. In some cases, WHO agrees to host a formal partnership without a separate legal personality. Hosting should be considered an exceptional arrangement that must be in the overwhelming interest of all parties.

10. For formal partnerships hosted by WHO, overarching considerations include ensuring that the overall mandate of the partnership and its hosting are consistent with WHO's constitutional mandate and principles and do not place additional burdens on the Organization, that it minimizes transaction costs to WHO, adds value to WHO's work, and adheres to WHO's accountability framework.

11. The decision for WHO to serve as the host will depend first and foremost on WHO's participation in the partnership as a strategic and technical partner. Most importantly, WHO must be a member of, and fully participate in, the steering body of the partnership. The partnership must also recognize, be in harmony with, and complement WHO's mandate and core functions, without duplicating or competing with them.

12. WHO will ensure that its hosting of the partnership and provision of its secretariat is congruent with WHO's accountability framework¹ and operational platform (covering political, legal, financial, communication and administrative activities) and protects WHO's integrity and reputation. The consideration and implementation of hosting arrangements will be in accordance with WHO's Constitution, Financial Regulations and Financial Rules, Staff Regulations and Staff Rules, and administrative and other relevant rules ("WHO's rules"). When WHO acts as the host, the operations of the partnership's secretariat must, in all respects, be administered in accordance with WHO's rules.

13. The hosting of a partnership by WHO goes beyond the simple provision of administrative services. The secretariat of a hosted partnership is part of WHO's Secretariat and, as such, shares the legal identity and status of the Organization. In particular, the staff of the partnership will, as staff members of WHO, enjoy the applicable privileges and immunities for the protection of their functions. To this end, it is essential that the function of the secretariat be, and be seen as, part of the functions of WHO. This consideration is particularly relevant for Switzerland, the host country of WHO's headquarters, which has granted privileges, immunities and facilities to the Organization and its staff

¹ With particular reference to Article 37 of WHO's Constitution which reads: "In the performance of their duties the Director-General and the staff shall not seek or receive instructions from any government or from any authority external to the Organization. They shall refrain from any action which might reflect on their position as international officers. Each Member of the Organization on its part undertakes to respect the exclusively international character of the Director-General and the staff and not to seek to influence them."

for the performance of its constitutional mandate. In order to comply with the host agreement between WHO and the Swiss Federal Council, the functions of the partnership secretariat must be part of the overall functions of WHO and may not be seen as separate from them. The Director-General will consult with the Swiss authorities when considering the hosting of formal partnerships.

14. The Director-General shall submit to the Executive Board any proposals for WHO to host formal partnerships for its review and decision.

Human resources

15. Although the organizational structure and specific duties of the partnership secretariat are normally determined by the steering body of the partnership, the secretariat staff are selected, managed and evaluated in accordance with WHO's rules. The staff members of the partnership secretariat will be recruited solely for service with the partnership secretariat.

16. As regards the head of a partnership secretariat, he or she will be appointed by the Director-General in compliance with WHO's Staff Regulations, Staff Rules and selection procedures and in consultation with the partnership's steering body. Similarly, the performance of the head of the partnership secretariat will be assessed under WHO's Performance Management and Development System, with an opportunity to receive feedback from the partnership's steering body.

Programme and financial management

17. Formal partnerships, where WHO's role is *not* exclusive in respect of governance, strategic and operational planning, will be outside the programme budget. This approach differentiates formal partnerships from WHO programmes. Separate accounts shall be established for each partnership so that relevant income and expenditure is recorded and reported upon in a manner separate from WHO's accounts. WHO shall invest any available balances of cash or cash equivalents in accordance with its own regulations for the use of the partnership. Although these partnerships are outside the programme budget, their work must be synergistic with WHO's respective strategic objectives.

18. Regardless of programme budget status, all payments from the respective partnership accounts must be in accordance with WHO's Financial Regulations and Financial Rules in order to enable appropriate monitoring of the financial accountability of grantees and other recipients and of progress towards programme objectives.

19. As regards financial management for formal partnerships outside the programme budget, the partnership secretariat will need to prepare separate financial statements of income and expenditure, certified by the Office of the Chief Accountant of WHO, which will be provided to the partnership's board on an annual basis. The statements will normally require a separate audit opinion from WHO's External Auditor. All partnerships are in addition subject to internal audit in accordance with WHO's Financial Regulations, Financial Rules and practices. Before the selection of a new head of a partnership secretariat, the Director-General may request an internal audit of the partnership.

20. As an exception to the above, a small number of formal partnerships exists in which WHO's role in respect of governance is not exclusive, but where the partnerships concerned contribute directly and fully to the achievement of the Organization-wide expected results and indicators as set out in the Programme budget. The work of these entities is exclusive to and follow strictly WHO's results hierarchy. These partnerships are included within the programme budget under the budget segment "Special programmes and collaborative arrangements". Most notable in this small group are long-

established research programmes whose activities have been embedded in WHO's work for many years.¹

21. Where WHO programmes provide direct contributions to supporting a hosted partnership, these costs shall be included in the WHO programme budget's relevant expected results, budget and workplans.

Resource mobilization and cost recovery

22. Each hosted partnership shall be responsible for mobilizing adequate funds for its effective operation, including the costs of its secretariat and all related activities provided for in its budget and workplan. The obligation of WHO to implement any particular aspect of the partnership's workplan will be conditional on WHO having received all necessary funding. Resource mobilization by hosted partnerships shall be closely coordinated with WHO, and those partnerships shall be required to indemnify the Organization for any financial risks and liabilities incurred by the latter in the performance of its hosting functions. Fundraising by a WHO-hosted partnership from the commercial private sector shall be subject to WHO's guidelines on interaction with commercial enterprises.

23. Unless otherwise stated in the hosting arrangement, WHO shall be reimbursed for its programme support costs as determined by the Health Assembly and/or WHO's internal policy. Hosted partnerships can impose heavy workloads on different parts of the Organization, including at regional and country levels. WHO will seek to be reimbursed for all administrative and technical support costs incurred in providing hosting functions for partnerships and implementing or supporting their activities. Similarly, partnerships that may have human resource implications for WHO at the regional and country levels shall be required to meet the related costs. Hosting arrangements will also require hosted partnerships to indemnify WHO for costs, expenses and claims incurred as a result of activities carried out by the partnership secretariat.

Communications

24. In order to protect the integrity of the partnership and of WHO, the partnership secretariat will follow WHO's guidelines and administrative procedures for internal and external communications (including media products, publications, technical reports and advocacy material). Official communications by the partnership secretariat with Member States, WHO offices and staff will follow WHO's normal channels.

Evaluation and "sunset clauses"

25. WHO's arrangements with all its hosted partnerships will contain an "evaluation and sunset clause", whereby an assessment will be carried out before the expiration of the hosting arrangement based on the past performance of the partnership, its relationship with WHO, the continued demand or emerging alternatives to fostering collaboration, and future expectations. Working with the partnerships, WHO will design a monitoring and evaluation framework for such an assessment.

26. Following the assessment, WHO and the partnership will discuss the results with a view to choosing one of four possible approaches, namely: (1) continuing the current arrangement for a new specified period; (2) making recommendations for changes to the partnership structure and/or purpose

¹ UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases and UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction.

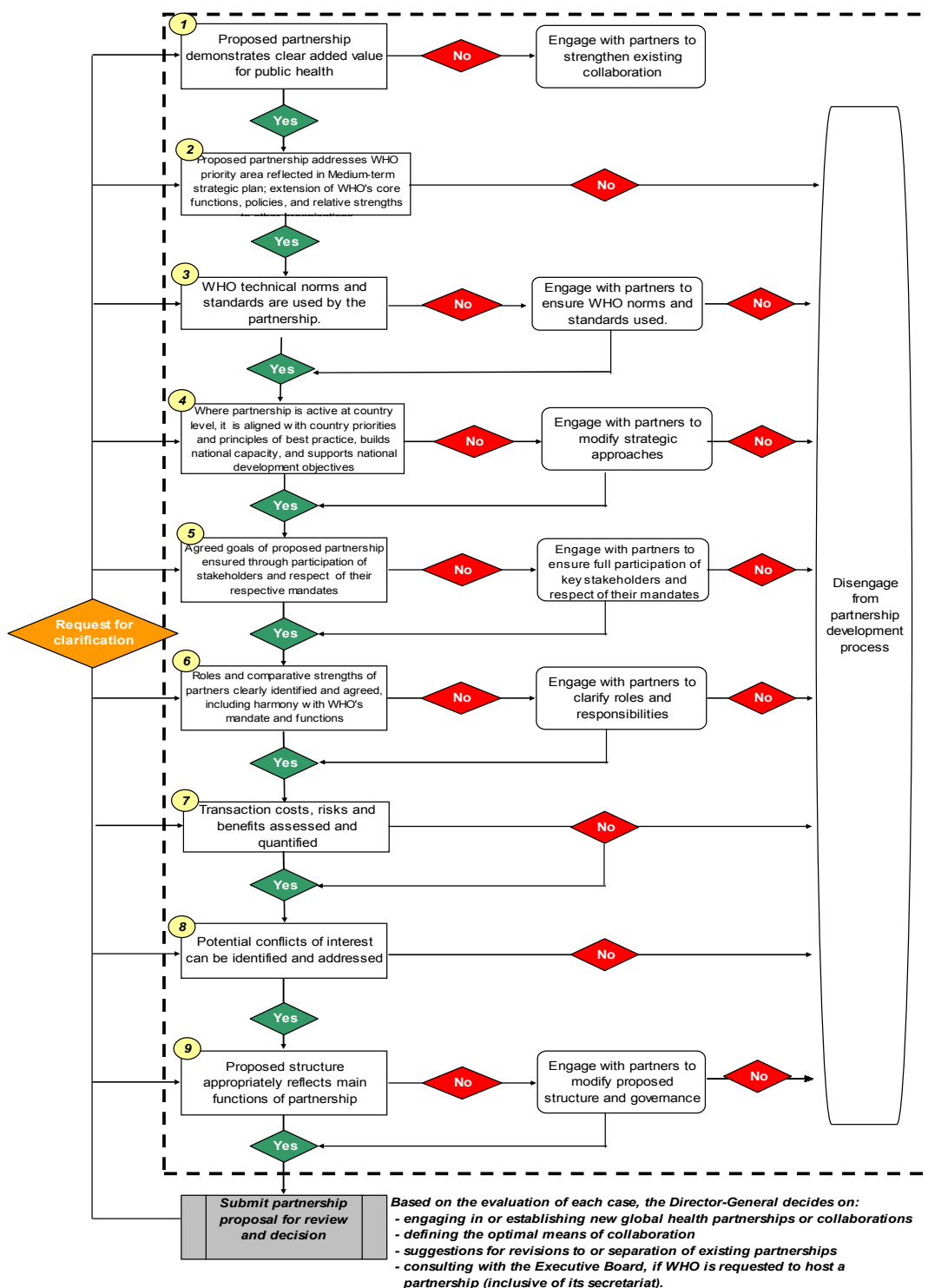
and for revision of WHO's hosting arrangement; (3) integrating the partnership into WHO with clear specifications for ensuring broad and inclusive collaboration with partners; or (4) separating the partnership from WHO.

27. The application and impact of this policy will be periodically reviewed and updated.

28. The Director-General will prepare guidelines and operating procedures for the implementation of this policy by the Secretariat.

APPENDIX

Decision tree for evaluating the criteria for WHO engagement



ANNEX 2

Text of amended Agreement between the Office International des Épizooties and the World Health Organization¹

[A63/46 – 22 April 2010]

Article 4

WHO and OIE shall collaborate in areas of common interest particularly by the following means:

4.1. Reciprocal exchange of reports, publications and other information, particularly the timely exchange of information on zoonotic and foodborne disease outbreaks. Special arrangements will be concluded between the two Parties to coordinate the response to outbreaks of zoonotic or/and foodborne diseases of recognized or potential international public health importance.

4.2. Organizing on both a regional and a world-wide basis meetings and conferences on zoonoses, food-borne diseases and related issues such as animal feeding practices and anti-microbial resistance related to the prudent use of antimicrobials in animal husbandry and their containment/control policies and programmes.

4.3. Joint elaboration, advocacy and technical support to national, regional or global programmes for the control or elimination of major zoonotic and foodborne diseases or emerging/re-emerging issues of common interest.

4.4. Promoting and strengthening, especially in developing countries, VPH education, operationalization of VPH and effective cooperation between the public health and animal health/veterinary sectors.

4.5. International promotion and coordination of research activities on zoonoses, VPH and food safety.

4.6. Promoting and strengthening collaboration between the network of OIE Reference Centres and Laboratories and that of WHO Collaborating Centres and Reference Laboratories to consolidate their support to WHO Member States and OIE Members on issues of common interest.

4.7. Joint development of international standards relating to relevant aspects in animal production which impact on food safety, in collaboration with other appropriate international agencies.

¹ See resolution WHA63.11.

ANNEX 3

Global strategy to reduce the harmful use of alcohol¹

[A63/13 – 25 March 2010]

Setting the scene

1. The harmful use of alcohol² has a serious effect on public health and is considered to be one of the main risk factors for poor health globally. In the context of this draft strategy, the concept of the harmful use of alcohol³ is broad and encompasses the drinking that causes detrimental health and social consequences for the drinker, the people around the drinker and society at large, as well as the patterns of drinking that are associated with increased risk of adverse health outcomes. The harmful use of alcohol compromises both individual and social development. It can ruin the lives of individuals, devastate families, and damage the fabric of communities.

2. The harmful use of alcohol is a significant contributor to the global burden of disease and is listed as the third leading risk factor for premature deaths and disabilities in the world.⁴ It is estimated that 2.5 million people worldwide died of alcohol-related causes in 2004, including 320 000 young people between 15 and 29 years of age. Harmful use of alcohol was responsible for 3.8% of all deaths in the world in 2004 and 4.5% of the global burden of disease as measured in disability-adjusted life years lost, even when consideration is given to the modest protective effects, especially on coronary heart disease, of low consumption of alcohol for some people aged 40 years or older.

3. Harmful drinking is a major avoidable risk factor for neuropsychiatric disorders and other noncommunicable diseases such as cardiovascular diseases, cirrhosis of the liver and various cancers. For some diseases there is no evidence of a threshold effect in the relationship between the risk and level of alcohol consumption. The harmful use of alcohol is also associated with several infectious diseases like HIV/AIDS, tuberculosis and pneumonia. A significant proportion of the disease burden attributable to harmful drinking arises from unintentional and intentional injuries, including those due to road traffic crashes and violence, and suicides. Fatal injuries attributable to alcohol consumption tend to occur in relatively young people.

4. The degree of risk for harmful use of alcohol varies with age, sex and other biological characteristics of the consumer as well as with the setting and context in which the drinking takes place. Some vulnerable or at-risk groups and individuals have increased susceptibility to the toxic, psychoactive and dependence-producing properties of ethanol. At the same time low risk patterns of

¹ See resolution WHA63.13.

² An alcoholic beverage is a liquid that contains ethanol (ethyl alcohol, commonly called “alcohol”) and is intended for drinking. In most countries with a legal definition of “alcoholic beverage” a threshold for content of ethanol by volume in a beverage is set at $\geq 0.5\%$ or 1.0% . The predominant categories of alcoholic beverages are beers, wines and spirits.

³ The word “harmful” in this strategy refers only to public-health effects of alcohol consumption, without prejudice to religious beliefs and cultural norms in any way.

⁴ See document A60/14 Add.1 for a global assessment of public-health problems caused by harmful use of alcohol, and *Global health risks: mortality and burden of disease attributable to selected major risk factors*. Geneva, World Health Organization, 2009.

alcohol consumption at the individual level may not be associated with occurrence or significantly increased probability of negative health and social consequences.

5. A substantial scientific knowledge base exists for policy-makers on the effectiveness and cost-effectiveness of strategies and interventions to prevent and reduce alcohol-related harm.¹ Although much of the evidence comes from high-income countries, the results of meta-analyses and reviews of the available evidence² provide sufficient knowledge to inform policy recommendations in terms of comparative effectiveness and cost-effectiveness of selected policy measures. With better awareness, there are increased responses at national, regional and global levels. However, these policy responses are often fragmented and do not always correspond to the magnitude of the impact on health and social development.

Challenges and opportunities

6. The present commitment to reducing the harmful use of alcohol provides a great opportunity for improving health and social well-being and for reducing the existing alcohol-attributable disease burden. However, there are considerable challenges that have to be taken into account in global or national initiatives or programmes. These include the following:

(a) **Increasing global action and international cooperation.** The current relevant health, cultural and market trends worldwide mean that harmful use of alcohol will continue to be a global health issue. These trends should be recognized and appropriate responses implemented at all levels. In this respect, there is a need for global guidance and increased international collaboration to support and complement regional and national actions.

(b) **Ensuring intersectoral action.** The diversity of alcohol-related problems and measures necessary to reduce alcohol-related harm points to the need for comprehensive action across numerous sectors. Policies to reduce the harmful use of alcohol must reach beyond the health sector, and appropriately engage such sectors as development, transport, justice, social welfare, fiscal policy, trade, agriculture, consumer policy, education and employment, as well as civil society and economic operators.

(c) **According appropriate attention.** Preventing and reducing harmful use of alcohol is often given a low priority among decision-makers despite compelling evidence of its serious public health effects. In addition, there is a clear discrepancy between the increasing availability and affordability of alcohol beverages in many developing and low- and middle-income countries and those countries' capability and capacity to meet the additional public health burden that follows. Unless this problem is given the attention it deserves, the spread of harmful drinking practices and norms will continue.

(d) **Balancing different interests.** Production, distribution, marketing and sales of alcohol create employment and generate considerable income for economic operators and tax revenue for governments at different levels. Public health measures to reduce harmful use of alcohol are sometimes judged to be in conflict with other goals like free markets and consumer choice and can be seen as harming economic interests and reducing government revenues. Policy-makers face the challenge of giving an appropriate priority to the promotion and protection of

¹ See document A60/14 for evidence-based strategies and interventions to reduce alcohol-related harm.

² See, for example: WHO Technical Report Series, No. 944, 2007 and *Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm*. Copenhagen, World Health Organization Regional Office for Europe, 2009.

population health while taking into account other goals, obligations, including international legal obligations, and interests. It should be noted in this respect that international trade agreements generally recognize the right of countries to take measures to protect human health, provided that these are not applied in a manner which would constitute a means of unjustifiable or arbitrary discrimination or disguised restrictions to trade. In this regard, national, regional and international efforts should take into account the impact of harmful use of alcohol.

(e) **Focusing on equity.** Population-wide rates of drinking of alcoholic beverages are markedly lower in poorer societies than in wealthier ones. However, for a given amount of consumption, poorer populations may experience disproportionately higher levels of alcohol-attributable harm. There is a great need to develop and implement effective policies and programmes that reduce such social disparities both inside a country and between countries. Such policies are also needed in order to generate and disseminate new knowledge about the complex relationship between harmful consumption of alcohol and social and health inequity, particularly among indigenous populations, minority or marginalized groups and in developing countries.

(f) **Considering the “context” in recommending actions.** Much of the published evidence of effectiveness of alcohol-related policy interventions comes from high-income countries, and concerns have been expressed that their effectiveness depends on context and may not be transferrable to other settings. However, many interventions to reduce harmful use of alcohol have been implemented in a wide variety of cultures and settings, and their results are often consistent and in line with the underpinning theories and evidence base accumulated in other similar public health areas. The focus for those developing and implementing policies should be on appropriate tailoring of effective interventions to accommodate local contexts and on appropriate monitoring and evaluation to provide feedback for further action.

(g) **Strengthening information.** Systems for collecting, analysing and disseminating data on alcohol consumption, alcohol-related harm and policy responses have been developed by Member States, the WHO Secretariat, and some other stakeholders. There are still substantial gaps in knowledge and it is important to sharpen the focus on information and knowledge production and dissemination for further developments in this area, especially in developing and low- and middle-income countries. The WHO Global Information System on Alcohol and Health and integrated regional information systems provide the means to monitor better progress made in reducing harmful use of alcohol at the global and regional levels.

Aims and objectives

7. National and local efforts can produce better results when they are supported by regional and global action within agreed policy frames. Thus the purpose of the global strategy is to support and complement public health policies in Member States.

8. The vision behind the global strategy is improved health and social outcomes for individuals, families and communities, with considerably reduced morbidity and mortality due to harmful use of alcohol and their ensuing social consequences. It is envisaged that the global strategy will promote and support local, regional and global actions to prevent and reduce the harmful use of alcohol.

9. The global strategy aims to give guidance for action at all levels; to set priority areas for global action; and to recommend a portfolio of policy options and measures that could be considered for implementation and adjusted as appropriate at the national level, taking into account national circumstances, such as religious and cultural contexts, national public health priorities, as well as resources, capacities and capabilities.

10. The strategy has five objectives:

- (a) raised global awareness of the magnitude and nature of the health, social and economic problems caused by harmful use of alcohol, and increased commitment by governments to act to address the harmful use of alcohol;
- (b) strengthened knowledge base on the magnitude and determinants of alcohol-related harm and on effective interventions to reduce and prevent such harm;
- (c) increased technical support to, and enhanced capacity of, Member States for preventing the harmful use of alcohol and managing alcohol-use disorders and associated health conditions;
- (d) strengthened partnerships and better coordination among stakeholders and increased mobilization of resources required for appropriate and concerted action to prevent the harmful use of alcohol;
- (e) improved systems for monitoring and surveillance at different levels, and more effective dissemination and application of information for advocacy, policy development and evaluation purposes.

11. The harmful use of alcohol and its related public health problems are influenced by the general level of alcohol consumption in a population, drinking patterns and local contexts. Achieving the five objectives will require global, regional and national actions on the levels, patterns and contexts of alcohol consumption and the wider social determinants of health. Special attention needs to be given to reducing harm to people other than the drinker and to populations that are at particular risk from harmful use of alcohol, such as children, adolescents, women of child-bearing age, pregnant and breastfeeding women, indigenous peoples and other minority groups or groups with low socioeconomic status.

Guiding principles

12. The protection of the health of the population by preventing and reducing the harmful use of alcohol is a public health priority. The following principles will guide the development and implementation of policies at all levels; they reflect the multifaceted determinants of alcohol-related harm and the concerted multisectoral actions required to implement effective interventions.

- (a) Public policies and interventions to prevent and reduce alcohol-related harm should be guided and formulated by public health interests and based on clear public health goals and the best available evidence.
- (b) Policies should be equitable and sensitive to national, religious and cultural contexts.
- (c) All involved parties have the responsibility to act in ways that do not undermine the implementation of public policies and interventions to prevent and reduce harmful use of alcohol.
- (d) Public health should be given proper deference in relation to competing interests and approaches that support that direction should be promoted.
- (e) Protection of populations at high risk of alcohol-attributable harm and those exposed to the effects of harmful drinking by others should be an integral part of policies addressing the harmful use of alcohol.

- (f) Individuals and families affected by the harmful use of alcohol should have access to affordable and effective prevention and care services.
- (g) Children, teenagers and adults who choose not to drink alcohol beverages have the right to be supported in their non-drinking behaviour and protected from pressures to drink.
- (h) Public policies and interventions to prevent and reduce alcohol-related harm should encompass all alcoholic beverages and surrogate alcohol.¹

National policies and measures

13. The harmful use of alcohol can be reduced if effective actions are taken by countries to protect their populations. Member States have a primary responsibility for formulating, implementing, monitoring and evaluating public policies to reduce the harmful use of alcohol. Such policies require a wide range of public health-oriented strategies for prevention and treatment. All countries will benefit from having a national strategy and appropriate legal frameworks to reduce harmful use of alcohol, regardless of the level of resources in the country. Depending on the characteristics of policy options and national circumstances, some policy options can be implemented by non-legal frameworks such as guidelines or voluntary restraints. Successful implementation of measures should be assisted by monitoring impact and compliance and establishing and imposing sanctions for non-compliance with adopted laws and regulations.

14. Sustained political commitment, effective coordination, sustainable funding and appropriate engagement of subnational governments as well as from civil society and economic operators are essential for success. Many relevant decision-making authorities should be involved in the formulation and implementation of alcohol policies, such as health ministries, transportation authorities or taxation agencies. Governments need to establish effective and permanent coordination machinery, such as a national alcohol council, comprising senior representatives of many ministries and other partners, in order to ensure a coherent approach to alcohol policies and a proper balance between policy goals in relation to harmful use of alcohol and other public policy goals.

15. Health ministries have a crucial role in bringing together the other ministries and stakeholders needed for effective policy design and implementation. They should also ensure that planning and provision of prevention and treatment strategies and interventions are coordinated with those for other related health conditions with high public health priority such as illicit drug use, mental illness, violence and injuries, cardiovascular diseases, cancer, tuberculosis and HIV/AIDS.

16. The policy options and interventions available for national action can be grouped into 10 recommended target areas, which should be seen as supportive and complementary to each other. These 10 areas are:

- (a) leadership, awareness and commitment
- (b) health services' response
- (c) community action

¹ In this strategy "surrogate alcohol" refers to liquids usually containing ethanol and not intended for consumption as beverages, that are consumed orally as substitutes for alcoholic beverages with the objective to producing intoxication or other effects associated with alcohol consumption.

- (d) drink–driving policies and countermeasures
- (e) availability of alcohol
- (f) marketing of alcoholic beverages
- (g) pricing policies
- (h) reducing the negative consequences of drinking and alcohol intoxication
- (i) reducing the public health impact of illicit alcohol and informally produced alcohol¹
- (j) monitoring and surveillance.

17. The policy options and interventions proposed below for consideration by Member States for each of the 10 recommended target areas are based on current scientific knowledge, available evidence on effectiveness and cost–effectiveness, experience and good practices. Not all the policy options and interventions will be applicable or relevant for all Member States and some may be beyond available resources. As such, the measures should be implemented at the discretion of each Member State depending on national, religious and cultural contexts, national public health priorities, and available resources, and in accordance with constitutional principles and international legal obligations. Policy measures and interventions at the national level will be supported and complemented by global and regional efforts to reduce the harmful use of alcohol.

POLICY OPTIONS AND INTERVENTIONS

Area 1. Leadership, awareness and commitment

18. Sustainable action requires strong leadership and a solid base of awareness and political will and commitment. The commitments should ideally be expressed through adequately funded comprehensive and intersectoral national policies that clarify the contributions, and division of responsibility, of the different partners involved. The policies must be based on available evidence and tailored to local circumstances, with clear objectives, strategies and targets. The policy should be accompanied by a specific action plan and supported by effective and sustainable implementation and evaluation mechanisms. The appropriate engagement of civil society and economic operators is essential.

19. For this area **policy options and interventions** include:

- (a) developing or strengthening existing, comprehensive national and subnational strategies, plans of action and activities to reduce the harmful use of alcohol;
- (b) establishing or appointing a main institution or agency, as appropriate, to be responsible for following up national policies, strategies and plans;

¹ “Informally produced alcohol” means alcoholic beverages produced at home or locally by fermentation and distillation of fruits, grains, vegetables and the like, and often within the context of local cultural practices and traditions. Examples of informally produced alcoholic beverages include sorghum beer, palm wine and spirits produced from sugar cane, grains or other commodities.

- (c) coordinating alcohol strategies with work in other relevant sectors, including cooperation between different levels of governments, and with other relevant health-sector strategies and plans;
- (d) ensuring broad access to information and effective education and public awareness programmes among all levels of society about the full range of alcohol-related harm experienced in the country and the need for, and existence of, effective preventive measures;
- (e) raising awareness of harm to others and among vulnerable groups caused by drinking, avoiding stigmatization and actively discouraging discrimination against affected groups and individuals.

Area 2. Health services' response

20. Health services are central to tackling harm at the individual level among those with alcohol-use disorders and other health conditions caused by harmful use of alcohol. Health services should provide prevention and treatment interventions to individuals and families at risk of, or affected by, alcohol-use disorders and associated conditions. Another important role of health services and health professionals is to inform societies about the public health and social consequences of harmful use of alcohol, support communities in their efforts to reduce the harmful use of alcohol, and to advocate effective societal responses. Health services should reach out to, mobilize and involve a broad range of players outside the health sector. Health services response should be sufficiently strengthened and funded in a way that is commensurate with the magnitude of the public health problems caused by harmful use of alcohol.

21. For this area **policy options and interventions** include:

- (a) increasing capacity of health and social welfare systems to deliver prevention, treatment and care for alcohol-use and alcohol-induced disorders and co-morbid conditions, including support and treatment for affected families and support for mutual help or self-help activities and programmes;
- (b) supporting initiatives for screening and brief interventions for hazardous and harmful drinking at primary health care and other settings; such initiatives should include early identification and management of harmful drinking among pregnant women and women of child-bearing age;
- (c) improving capacity for prevention of, identification of, and interventions for individuals and families living with fetal alcohol syndrome and a spectrum of associated disorders;
- (d) development and effective coordination of integrated and/or linked prevention, treatment and care strategies and services for alcohol-use disorders and co-morbid conditions, including drug-use disorders, depression, suicides, HIV/AIDS and tuberculosis;
- (e) securing universal access to health including through enhancing availability, accessibility and affordability of treatment services for groups of low socioeconomic status;
- (f) establishing and maintaining a system of registration and monitoring of alcohol-attributable morbidity and mortality, with regular reporting mechanisms;
- (g) provision of culturally sensitive health and social services as appropriate.

Area 3. Community action

22. The impact of harmful use of alcohol on communities can trigger and foster local initiatives and solutions to local problems. Communities can be supported and empowered by governments and other stakeholders to use their local knowledge and expertise in adopting effective approaches to prevent and reduce the harmful use of alcohol by changing collective rather than individual behaviour while being sensitive to cultural norms, beliefs and value systems.

23. For this area **policy options and interventions** include:

- (a) supporting rapid assessments in order to identify gaps and priority areas for interventions at the community level;
- (b) facilitating increased recognition of alcohol-related harm at the local level and promoting appropriate effective and cost-effective responses to the local determinants of harmful use of alcohol and related problems;
- (c) strengthening capacity of local authorities to encourage and coordinate concerted community action by supporting and promoting the development of municipal policies to reduce harmful use of alcohol, as well as their capacity to enhance partnerships and networks of community institutions and nongovernmental organizations;
- (d) providing information about effective community-based interventions, and building capacity at community level for their implementation;
- (e) mobilizing communities to prevent the selling of alcohol to, and consumption of alcohol by, under-age drinkers, and to develop and support alcohol-free environments, especially for youth and other at-risk groups;
- (f) providing community care and support for affected individuals and their families;
- (g) developing or supporting community programmes and policies for subpopulations at particular risk, such as young people, unemployed persons and indigenous populations, specific issues like the production and distribution of illicit or informal-alcohol beverages and events at community level such as sporting events and town festivals.

Area 4. Drink-driving policies and countermeasures

24. Driving under the influence of alcohol seriously affects a person's judgment, coordination and other motor functions. Alcohol-impaired driving is a significant public health problem that affects both the drinker and in many cases innocent parties. Strong evidence-based interventions exist for reducing drink-driving. Strategies to reduce harm associated with drink-driving should include deterrent measures that aim to reduce the likelihood that a person will drive under the influence of alcohol, and measures that create a safer driving environment in order to reduce both the likelihood and severity of harm associated with alcohol-influenced crashes.

25. In some countries, the number of traffic-related injuries involving intoxicated pedestrians is substantial and should be a high priority for intervention.

26. For this area **policy options and interventions** include:

- (a) introducing and enforcing an upper limit for blood alcohol concentration, with a reduced limit for professional drivers and young or novice drivers;
- (b) promoting sobriety check points and random breath-testing;
- (c) administrative suspension of driving licences;
- (d) graduated licensing for novice drivers with zero-tolerance for drink-driving;
- (e) using an ignition interlock, in specific contexts where affordable, to reduce drink-driving incidents;
- (f) mandatory driver-education, counselling and, as appropriate, treatment programmes;
- (g) encouraging provision of alternative transportation, including public transport until after the closing time for drinking places;
- (h) conducting public awareness and information campaigns in support of policy and in order to increase the general deterrence effect;
- (i) running carefully planned, high-intensity, well-executed mass media campaigns targeted at specific situations, such as holiday seasons, or audiences such as young people.

Area 5. Availability of alcohol

27. Public health strategies that seek to regulate the commercial or public availability of alcohol through laws, policies, and programmes are important ways to reduce the general level of harmful use of alcohol. Such strategies provide essential measures to prevent easy access to alcohol by vulnerable and high-risk groups. Commercial and public availability of alcohol can have a reciprocal influence on the social availability of alcohol and thus contribute to changing social and cultural norms that promotes harmful use of alcohol. The level of regulation on the availability of alcohol will depend on local circumstances, including social, cultural and economic contexts as well as existing binding international obligations. In some developing and low- and middle-income countries, informal markets are the main source of alcohol and formal controls on sale need to be complemented by actions addressing illicit or informally produced alcohol. Furthermore, restrictions on availability that are too strict may promote the development of a parallel illicit market. Secondary supply of alcohol, for example from parents or friends, needs also to be taken into consideration in measures on the availability of alcohol.

28. For this area **policy options and interventions** include:

- (a) establishing, operating and enforcing an appropriate system to regulate production, wholesaling and serving of alcoholic beverages that places reasonable limitations on the distribution of alcohol and the operation of alcohol outlets in accordance with cultural norms, by the following possible measures:
 - (i) introducing, where appropriate, a licensing system on retail sales, or public health-oriented government monopolies;
 - (ii) regulating the number and location of on-premise and off-premise alcohol outlets;

- (iii) regulating days and hours of retail sales;
 - (iv) regulating modes of retail sales of alcohol;
 - (v) regulating retail sales in certain places or during special events;
- (b) establishing an appropriate minimum age for purchase or consumption of alcoholic beverages and other policies in order to raise barriers against sales to, and consumption of alcoholic beverages by, adolescents;
- (c) adopting policies to prevent sales to intoxicated persons and those below the legal age and considering the introduction of mechanisms for placing liability on sellers and servers in accordance with national legislations;
- (d) setting policies regarding drinking in public places or at official public agencies' activities and functions;
- (e) adopting policies to reduce and eliminate availability of illicit production, sale and distribution of alcoholic beverages as well as to regulate or control informal alcohol.

Area 6. Marketing¹ of alcoholic beverages

29. Reducing the impact of marketing, particularly on young people and adolescents, is an important consideration in reducing harmful use of alcohol. Alcohol is marketed through increasingly sophisticated advertising and promotion techniques, including linking alcohol brands to sports and cultural activities, sponsorships and product placements, and new marketing techniques such as e-mails, SMS and podcasting, social media and other communication techniques. The transmission of alcohol marketing messages across national borders and jurisdictions on channels such as satellite television and the Internet, and sponsorship of sports and cultural events is emerging as a serious concern in some countries.

30. It is very difficult to target young adult consumers without exposing cohorts of adolescents under the legal age to the same marketing. The exposure of children and young people to appealing marketing is of particular concern, as is the targeting of new markets in developing and low- and middle-income countries with a current low prevalence of alcohol consumption or high abstinence rates. Both the content of alcohol marketing and the amount of exposure of young people to that marketing are crucial issues. A precautionary approach to protecting young people against these marketing techniques should be considered.

31. For this area **policy options and interventions** include:

- (a) setting up regulatory or co-regulatory frameworks, preferably with a legislative basis, and supported when appropriate by self-regulatory measures, for alcohol marketing by:
 - (i) regulating the content and the volume of marketing;

¹ Marketing could refer, as appropriate and in accordance with national legislation, to any form of commercial communication or message that is designed to increase, or has the effect of increasing, the recognition, appeal and/or consumption of particular products and services. It could comprise anything that acts to advertise or otherwise promote a product or service.

- (ii) regulating direct or indirect marketing in certain or all media;
 - (iii) regulating sponsorship activities that promote alcoholic beverages;
 - (iv) restricting or banning promotions in connection with activities targeting young people;
 - (v) regulating new forms of alcohol marketing techniques, for instance social media;
- (b) development by public agencies or independent bodies of effective systems of surveillance of marketing of alcohol products;
- (c) setting up effective administrative and deterrence systems for infringements on marketing restrictions.

Area 7. Pricing policies

32. Consumers, including heavy drinkers and young people, are sensitive to changes in the price of drinks. Pricing policies can be used to reduce underage drinking, to halt progression towards drinking large volumes of alcohol and/or episodes of heavy drinking, and to influence consumers' preferences. Increasing the price of alcoholic beverages is one of the most effective interventions to reduce harmful use of alcohol. A key factor for the success of price-related policies in reducing harmful use of alcohol is an effective and efficient system for taxation matched by adequate tax collection and enforcement.

33. Factors such as consumer preferences and choice, changes in income, alternative sources for alcohol in the country or in neighbouring countries, and the presence or absence of other alcohol policy measures may influence the effectiveness of this policy option. Demand for different beverages may be affected differently. Tax increases can have different impacts on sales, depending on how they affect the price to the consumer. The existence of a substantial illicit market for alcohol complicates policy considerations on taxation in many countries. In such circumstances tax changes must be accompanied by efforts to bring the illicit and informal markets under effective government control. Increased taxation can also meet resistance from consumer groups and economic operators, and taxation policy will benefit from the support of information and awareness-building measures to counter such resistance.

34. For this area **policy options and interventions** include:

- (a) establishing a system for specific domestic taxation, on alcohol accompanied by an effective enforcement system, which may take into account, as appropriate, the alcoholic content of the beverage;
- (b) regularly reviewing prices in relation to level of inflation and income;
- (c) banning or restricting the use of direct and indirect price promotions, discount sales, sales below cost and flat rates for unlimited drinking or other types of volume sales;
- (d) establishing minimum prices for alcohol where applicable;
- (e) providing price incentives for non-alcoholic beverages;
- (f) reducing or stopping subsidies to economic operators in the area of alcohol.

Area 8. Reducing the negative consequences of drinking and alcohol intoxication

35. This target area includes policy options and interventions that focus directly on reducing the harm from alcohol intoxication and drinking without necessarily affecting the underlying alcohol consumption. Current evidence and good practices favour the complementary use of interventions within a broader strategy that prevents or reduces the negative consequences of drinking and alcohol intoxication. In implementing these approaches, managing the drinking environment or informing consumers, the perception of endorsing or promoting drinking should be avoided.

36. For this area **policy options and interventions** include:

- (a) regulating the drinking context in order to minimize violence and disruptive behaviour, including serving alcohol in plastic containers or shatter-proof glass and management of alcohol-related issues at large-scale public events;
- (b) enforcing laws against serving to intoxication and legal liability for consequences of harm resulting from intoxication caused by the serving of alcohol;
- (c) enacting management policies relating to responsible serving of beverage on premises and training staff in relevant sectors in how better to prevent, identify and manage intoxicated and aggressive drinkers;
- (d) reducing the alcoholic strength inside different beverage categories;
- (e) providing necessary care or shelter for severely intoxicated people;
- (f) providing consumer information about, and labelling alcoholic beverages to indicate, the harm related to alcohol.

Area 9. Reducing the public health impact of illicit alcohol and informally produced alcohol

37. Consumption of illicitly or informally produced alcohol could have additional negative health consequences due to a higher ethanol content and potential contamination with toxic substances, such as methanol. It may also hamper governments' abilities to tax and control legally produced alcohol. Actions to reduce these additional negative effects should be taken according to the prevalence of illicit and/or informal alcohol consumption and the associated harm. Good scientific, technical and institutional capacity should be in place for the planning and implementation of appropriate national, regional and international measures. Good market knowledge and insight into the composition and production of informal or illicit alcohol are also important, coupled with an appropriate legislative framework and active enforcement. These interventions should complement, not replace, other interventions to reduce harmful use of alcohol.

38. Production and sale of informal alcohol are ingrained in many cultures and are often informally controlled. Thus control measures could be different for illicit alcohol and informally produced alcohol and should be combined with awareness raising and community mobilization. Efforts to stimulate alternative sources of income are also important.

39. For this area **policy options and interventions** include:

- (a) good quality control with regard to production and distribution of alcoholic beverages;
- (b) regulating sales of informally produced alcohol and bringing it into the taxation system;

- (c) an efficient control and enforcement system, including tax stamps;
- (d) developing or strengthening tracking and tracing systems for illicit alcohol;
- (e) ensuring necessary cooperation and exchange of relevant information on combating illicit alcohol among authorities at national and international levels;
- (f) issuing relevant public warnings about contaminants and other health threats from informal or illicit alcohol.

Area 10. Monitoring and surveillance

40. Data from monitoring and surveillance create the basis for the success and appropriate delivery of the other nine policy options. Local, national and international monitoring and surveillance are needed in order to monitor the magnitude and trends of alcohol-related harms, to strengthen advocacy, to formulate policies and to assess impact of interventions. Monitoring should also capture the profile of people accessing services and the reason why people most affected are not accessing prevention and treatment services. Data may be available in other sectors, and good systems for coordination, information exchange and collaboration are necessary in order to collect the potentially broad range of information needed to have comprehensive monitoring and surveillance.

41. Development of sustainable national information systems using indicators, definitions and data-collection procedures compatible with WHO's global and regional information systems provides an important basis for effective evaluation of national efforts to reduce harmful use of alcohol and for monitoring trends at subregional, regional and global levels. Systematic continual collection, collation and analysis of data, timely dissemination of information and feedback to policy-makers and other stakeholders should be an integral part of implementation of any policy and intervention to reduce harmful use of alcohol. Collecting, analysing and disseminating information on harmful use of alcohol are resource-intensive activities.

42. For this area **policy options and interventions** include:

- (a) establishing effective frameworks for monitoring and surveillance activities including periodic national surveys on alcohol consumption and alcohol-related harm and a plan for exchange and dissemination of information;
- (b) establishing or designating an institution or other organizational entity responsible for collecting, collating, analysing and disseminating available data, including publishing national reports;
- (c) defining and tracking a common set of indicators of harmful use of alcohol and of policy responses and interventions to prevent and reduce such use;
- (d) creating a repository of data at the country level based on internationally agreed indicators and reporting data in the agreed format to WHO and other relevant international organizations;
- (e) developing evaluation mechanisms with the collected data in order to determine the impact of policy measures, interventions and programmes put in place to reduce the harmful use of alcohol.

GLOBAL ACTION: KEY ROLES AND COMPONENTS

43. Given the magnitude and the complexity of the problem, concerted global efforts must be in place to support Member States in the challenges they face at the national level. International coordination and collaboration create the synergies that are needed and provide increased leverage for Member States to implement evidence-based measures.

44. WHO, in cooperation with other organizations in the United Nations system and other international partners will:

- (a) provide leadership;
- (b) strengthen advocacy;
- (c) formulate, in collaboration with Member States, evidence-based policy options;
- (d) promote networking and exchange of experience among countries;
- (e) strengthen partnerships and resource mobilization;
- (f) coordinate monitoring of alcohol-related harm and the progress countries are making to address it.

45. Action by WHO and other international partners to support the implementation of the global strategy will be taken according to their mandates. International nongovernmental organizations, professional associations, research institutions and economic operators in the area of alcohol, all have important roles in enhancing the global action, as follows.

- (a) Major partners within the United Nations system and intergovernmental organizations like ILO, UNICEF, WTO, UNDP, UNFPA, UNAIDS, United Nations Office on Drugs and Crime, and the World Bank group will be urged to increase collaboration and cooperation to prevent and reduce harmful use of alcohol, especially in developing and low- and middle-income countries.
- (b) Civil society has an important role in warning about the impact of harmful use of alcohol on individuals, families and communities and in bringing additional commitment and resources for reducing alcohol-related harm. Nongovernmental organizations are especially encouraged to form wide networks and action groups to support the implementation of the global strategy.
- (c) Research institutions and professional associations play a pivotal role in generating additional evidence for action and disseminating this to health professionals and the wider community. WHO collaborating centres have an important role in supporting the implementation and evaluation of the global strategy.
- (d) Economic operators in alcohol production and trade are important players in their role as developers, producers, distributors, marketers and sellers of alcoholic beverages. They are especially encouraged to consider effective ways to prevent and reduce harmful use of alcohol within their core roles mentioned above, including self-regulatory actions and initiatives. They could also contribute by making available data on sales and consumption of alcohol beverages.

- (e) The media play an increasingly important role, not only as a conveyer of news and information but also as a channel for commercial communications, and will be encouraged to support the intentions and activities of the global strategy.

Public health advocacy and partnership

46. International public health advocacy and partnership are needed for strengthened commitment and abilities of the governments and all relevant parties at all levels for reducing harmful use of alcohol worldwide.

47. WHO is committed to raising awareness of the public health problems caused by harmful use of alcohol and of the steps that can be taken to prevent and reduce such use in order to save lives and reduce suffering. WHO will engage with other international intergovernmental organizations and, as appropriate, international bodies representing key stakeholders, to ensure that relevant actors can contribute to reducing the harmful use of alcohol.

48. The Secretariat will provide support to Member States by:

- (a) raising the awareness of the magnitude of public health problems caused by harmful use of alcohol and advocating for appropriate action at all levels to prevent and reduce such problems;
- (b) advocating that attention is given to addressing the harmful use of alcohol in the agendas of relevant international and intergovernmental organizations in order to support policy coherence between health and other sectors at regional and global levels;
- (c) promoting and facilitating international coordination, collaboration, partnerships and information exchange to ensure the needed synergies and concerted actions of all relevant parties;
- (d) ensuring consistency, scientific soundness and clarity of key messages about preventing and reducing harmful use of alcohol;
- (e) promoting intercountry networking and exchange of experiences;
- (f) facilitating international networking in order to tackle specific and similar problems (for example, specific problems among indigenous or other minority groups or changing youth drinking cultures);
- (g) advocating appropriate consideration by parties in international, regional and bilateral trade negotiations to the need and the ability of national and subnational governments to regulate alcohol distribution, sales and marketing, and thus to manage alcohol-related health and social costs;
- (h) ensuring that the WHO Secretariat has processes in place to work with nongovernmental organizations and other civil society groups, taking into consideration any conflicts of interest that some nongovernmental organizations may have;
- (i) continuing its dialogue with the private sector on how they best can contribute to the reduction of alcohol-related harm. Appropriate consideration will be given to the commercial interests involved and their possible conflict with public health objectives.

Technical support and capacity building

49. Many Member States need increased capacity and capability to create, enforce and sustain the necessary policy and legal frames and implementation mechanisms. Global action will support national action through the development of sustainable mechanisms and the provision of the necessary normative guidance and technical tools for effective technical support and capacity building, with particular focus on developing and low- and middle-income countries. Such actions must be in accordance with the national contexts, needs and priorities. Development of the necessary infrastructure for effective policy responses in countries with higher or increasing alcohol-attributable burden is an important prerequisite for attaining broader public health and developmental objectives.

50. WHO is committed to cooperate with other relevant actors at regional and global levels in order to provide technical guidance and support for strengthening institutional capacity to respond to public health problems caused by harmful use of alcohol. WHO will especially focus on support and building capacity in developing and low- and middle-income countries.

51. The Secretariat will provide support to Member States by:

- (a) documenting and disseminating good models of health-service responses to alcohol-related problems;
- (b) documenting and disseminating best practices and models of responses to alcohol-related problems in different sectors;
- (c) drawing on expertise in other areas like road safety, taxation and justice with public health expertise in order to design effective models to prevent and reduce alcohol-related harm;
- (d) providing normative guidance on effective and cost-effective prevention and treatment interventions in different settings;
- (e) developing and strengthening global, regional and intercountry networks in order to help in sharing best practices and facilitating capacity building;
- (f) responding to Member States' requests for support of their efforts to build the capacity to understand the implications of international trade and trade agreements for health.

Production and dissemination of knowledge

52. Important areas for global action will be monitoring trends in alcohol consumption, alcohol-attributable harm and the societal responses, analysing this information and facilitating timely dissemination. Available knowledge on the magnitude of harmful use of alcohol, and effectiveness and cost-effectiveness of preventive and treatment interventions should be further consolidated and expanded systematically at the global level, especially information on epidemiology of alcohol use and alcohol-related harm, impact of harmful use of alcohol on economic and social development and the spread of infectious diseases in developing and low- and middle-income countries.

53. The Global Information System on Alcohol and Health and its regional components were developed by WHO for dynamic presentation of the data on levels and patterns of alcohol consumption, alcohol-attributable health and social consequences and policy responses at all levels. Improving the global and regional data on alcohol and health requires development of national monitoring systems, regular reporting of data by designated focal points to WHO and strengthening the relevant surveillance activities.

54. WHO is committed to working with the relevant partners to shape the international research agenda on alcohol and health, build capacity for research and promote and support international research networks and projects to generate and disseminate data to inform policy and programme development.

55. The Secretariat will provide support to Member States by:

- (a) providing an international clearinghouse for information on effective and cost-effective interventions to reduce harmful use of alcohol including promoting and facilitating exchange of information about effective treatment services;
- (b) strengthening the Global Information System on Alcohol and Health and the comparative risk assessment of the alcohol-attributable disease burden;
- (c) developing or refining appropriate data-collection mechanisms, based on comparable data and agreed indicators and definitions, in order to facilitate data collection, collation, analysis and dissemination at the global, regional and national levels;
- (d) facilitating regional and global networks to support and complement national efforts, with a focus on knowledge production and information exchange;
- (e) continuing its collaboration with international networks of scientists and health experts to promote research on various aspects of harmful use of alcohol;
- (f) facilitating comparative effectiveness studies of different policy measures implemented in different cultural and developmental contexts;
- (g) facilitating operational research to expand effective interventions and research on the relationship between harmful use of alcohol and social and health inequities.

Resource mobilization

56. The magnitude of alcohol-attributable disease and social burden is in sharp contradiction with the resources available at all levels to reduce harmful use of alcohol. Global development initiatives must take into account that developing and low- and middle-income countries need technical support – through aid and expertise – to establish and strengthen national policies and plans for the prevention of harmful use of alcohol and develop appropriate infrastructures, including those in health-care systems. Development agencies could consider reducing harmful use of alcohol as a priority area in developing and low- and middle-income countries with a high burden of disease attributable to harmful use of alcohol. Official development assistance provides opportunities to build sustainable institutional capacity in this area in developing and low- and middle-income countries, as do mechanisms for collaboration between developing countries. In that regard, Member States are urged to support each other in the implementation of the global strategy through international cooperation and financial assistance including official development assistance for developing countries.

57. WHO is committed to assist countries upon request in resource mobilization and pooling of available resources to support global and national action to reduce harmful use of alcohol in identified priority areas.

58. The Secretariat will provide support to Member States by:

- (a) promoting exchange of experience and good practice in financing policies and interventions to reduce harmful use of alcohol;
- (b) exploring new or innovative ways and means to secure adequate funding for implementation of the global strategy;
- (c) collaborating with international partners, intergovernmental partners and donors to mobilize necessary resources to support developing and low- and middle-income countries in their efforts to reduce harmful use of alcohol.

IMPLEMENTING THE STRATEGY

59. Successful implementation of the strategy will require concerted action by Member States, effective global governance and appropriate engagement of all relevant stakeholders. All actions listed in the strategy are proposed to support the achievement of the five objectives.

60. The Secretariat will report regularly on the global burden of alcohol-related harm, make evidence-based recommendations, and advocate action at all levels to prevent and reduce harmful use of alcohol. It will collaborate with other intergovernmental organizations and, as appropriate, other international bodies representing key stakeholders to ensure that action to reduce harmful use of alcohol receives appropriate priority and resources.

Links and interfaces with other strategies, plans and programmes

61. This global strategy builds upon regional initiatives such as the Framework for alcohol policy in the WHO European Region (resolution EUR/RC55/R1), the Regional strategy to reduce alcohol-related harm in the Western Pacific Region (resolution WPR/RC57.R5), Alcohol consumption control – policy options in the South-East Asia Region (resolution SEA/RC59/R8), Public health problems of alcohol consumption in the Eastern Mediterranean Region (resolution EM/RC53/R.5) and Actions to reduce the harmful use of alcohol in the African Region (document AFR/RC58/3).

62. Harmful use of alcohol is one of the four main risk factors highlighted in the action plan for the global strategy for the prevention and control of noncommunicable diseases (resolution WHA61.14). The strategy to reduce harmful use of alcohol builds on and links to the other risk factors for noncommunicable diseases and the disease-specific programmes, especially through the global strategy on diet, physical activity and health (resolution WHA57.17), tobacco control (resolution WHA56.1), health promotion and healthy lifestyle (resolution WHA57.16) and cancer prevention and control (resolution WHA58.22).

63. The strategy also links and aligns itself with other related activities in WHO, especially the Mental Health Gap Action Programme, including suicide prevention and management of other substance use disorders as well as programmatic activities on violence and health (resolution WHA56.24), road safety and health (resolution WHA57.10), child and adolescent health and development (resolution WHA56.21) and reproductive health (resolution WHA57.12).

64. With emerging evidence, greater attention is being given to the links between harmful use of alcohol and some infectious diseases and between harmful drinking and development. The strategy also links in with WHO's existing programmes on HIV/AIDS and tuberculosis and its work on reducing health inequities through action on the social determinants of health (resolution WHA62.14)

and achieving the health-related development goals including those contained in the United Nations Millennium Declaration (resolution WHA58.30).

65. The implementation of a global strategy to reduce harmful use of alcohol provides a supportive framework for the WHO regional offices to formulate, revisit and implement region-specific policies and, together with the country offices, provide technical support to Member States. Emphasis will also be put on coordination within the Secretariat so that all actions relevant to harmful use of alcohol are in line with this strategy.

Monitoring progress and reporting mechanisms

66. For monitoring progress, the strategy requires appropriate mechanisms at different levels for assessment, reporting and re-programming. A framework with an impact-focused perspective is needed for assessing achievement of the strategy's objectives.

67. WHO's Global Survey on Alcohol and Health and the Global Information System on Alcohol and Health will be important parts of the reporting and monitoring mechanisms. The data-collecting tools of the latter will be adjusted to include the relevant reporting on the process and outcomes of implementation of the strategy at the national level.

68. Regular meetings of global and regional networks of national counterparts offer a mechanism for technical discussion of the implementation of the global strategy at different levels. In addition to taking stock of the process, these meetings could include detailed discussions of priority areas and topics relevant to implementation.

69. Reporting on the implementation of the global strategy to Member States will take place through regular reports to WHO regional committees and the Health Assembly. Information about implementation and progress should also be presented at regional or international forums and appropriate intergovernmental meetings.

ANNEX 4

Set of recommendations on the marketing of foods and non-alcoholic beverages to children¹

[A63/12 – 1 April 2010]

1. The Sixtieth World Health Assembly, in resolution WHA60.23 on prevention and control of noncommunicable diseases: implementation of the global strategy, requested the Director-General “to promote responsible marketing including the development of a set of recommendations on the marketing of foods and non-alcoholic beverages to children, in order to reduce the impact of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt, in dialogue with all relevant stakeholders, including private-sector parties, while ensuring avoidance of potential conflict of interest”.
2. The Sixty-first World Health Assembly in resolution WHA61.14 endorsed the action plan for the global strategy for the prevention and control of noncommunicable diseases. The action plan urges Member States to continue to implement the actions agreed by the Health Assembly in resolution WHA60.23. In Objective 3 (paragraph 24, *Promoting healthy diet*, (e)) the action plan identifies as a proposed key action for Member States “to prepare and put in place, as appropriate, and with all relevant stakeholders, a framework and/or mechanisms for promoting the responsible marketing of foods and non-alcoholic beverages to children, in order to reduce the impact of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt”.
3. In the fulfilment of this mandate, in November 2008, the Director-General appointed members of an ad hoc expert group to provide her with technical advice on appropriate policy objectives, policy options and monitoring and evaluation mechanisms. The group was provided with an updated systematic review that confirmed previous findings that globally foods high in fat, sugar or salt were being extensively marketed to children.
4. Two meetings were held with representatives of international nongovernmental organizations, the global food and non-alcoholic beverage industries, and the advertising sector. The objectives of these meetings were to identify policy initiatives and processes and tools for monitoring and evaluation in the area of marketing of foods and non-alcoholic beverages to children.
5. The Secretariat drew on the advice from the expert group and input from the stakeholder meetings to write a working paper that provided a framework for regional consultations with Member States. These consultations elicited the views of Member States on the policy objectives, policy options, and monitoring and evaluation mechanisms presented in the working paper. By September 2009, 66 Member States had submitted a response to the consultations. Additional input on the working paper was provided through two follow-up stakeholder meetings with representatives of international nongovernmental organizations, the global food and non-alcoholic beverage industries, and the advertising sector.
6. It was clear from the consultations that Member States view marketing of foods and non-alcoholic beverages to children as an international issue and that there is a need to ensure that the

¹ See resolution WHA63.14; see Annex 9 for the financial and administrative implications for the Secretariat of this resolution.

private sector markets its products responsibly. The consultations also showed that policies currently in place in Member States vary in their objectives and content, approach, monitoring and evaluation practices, and the ways in which stakeholders are involved. Approaches range from statutory prohibitions on television advertising for children of predefined foods to voluntary codes by certain sections of the food and advertising industry. Several Member States indicated that they would need further support from the Secretariat in the areas of policy development, monitoring and evaluation.

7. Cross-border marketing was raised as a concern by 15 Member States. Many countries, including those with restrictions in place, are exposed to food marketing in their country from beyond their borders and the Member States indicated that the global nature of many marketing practices needs to be addressed.

8. Marketing of foods and non-alcoholic beverages to children in schools and pre-school establishments was a concern expressed by some Member States. The special situation of schools as a setting where children are a captive audience and the health-promoting role that schools should have were identified as factors that need also to be addressed in the recommendations.

9. The main purpose of these recommendations is to guide efforts by Member States in designing new and/or strengthening existing policies on food marketing communications to children in order to reduce the impact on children of marketing of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt.

10. The recommendations are set out in **bold** text throughout this Annex. The recommendations are structured into the following five sections: Rationale; Policy development; Policy implementation; Policy monitoring and evaluation; and Research.

EVIDENCE

11. Unhealthy diet is a risk factor for noncommunicable diseases. The risks presented by unhealthy diets start in childhood and build up throughout life. In order to reduce future risk of noncommunicable diseases children should maintain a healthy weight and consume foods that are low in saturated fat, *trans*-fatty acids, free sugars, and salt. Unhealthy diets are associated with overweight and obesity, conditions that have increased rapidly in children around the world over recent years.

12. Evidence from systematic reviews on the extent, nature and effects of food marketing to children conclude that advertising is extensive and other forms of food¹ marketing² to children are widespread across the world.³ Most of this marketing is for foods with a high content of fat, sugar or

¹ Henceforth, the term “food” is used to refer to foods and non-alcoholic beverages.

² “Marketing” refers to any form of commercial communication or message that is designed to increase, or has the effect of increasing, the recognition, appeal and/or consumption of particular products and services. It comprises anything that acts to advertise or otherwise promote a product or service.

³ Hastings G et al. *Review of the research on the effects of food promotion to children*. Glasgow, University of Strathclyde, Centre for Social Marketing; 2003 (<http://www.food.gov.uk/news/newsarchive/2003/sep/promote>); Hastings G et al. *The extent, nature and effects of food promotion to children: a review of the evidence*. Geneva, World Health Organization, 2006 (http://whqlibdoc.who.int/publications/2007/9789241595247_eng.pdf); McGinnis JM, Gootman JA, Kraak VI, eds. *Food marketing to children and youth: threat or opportunity?* Washington DC, Institute of Medicine, National Academies Press, 2006 (http://www.nap.edu/catalog.php?record_id=11514#toc); and Cairns G, Angus K, Hastings G. *The extent, nature and effects of food promotion to children: a review of the evidence to December 2008*. Geneva, World Health Organization, 2009 (http://www.who.int/dietphysicalactivity/Evidence_Update_2009.pdf).

salt. Evidence also shows that television advertising influences children's food preferences, purchase requests and consumption patterns.

13. The systematic reviews show that, although television remains an important medium, it is gradually being complemented by an increasingly multifaceted mix of marketing communications that focuses on branding and building relationships with consumers. This wide array of marketing techniques includes advertising, sponsorship, product placement, sales promotion, cross-promotions using celebrities, brand mascots or characters popular with children, web sites, packaging, labelling and point-of-purchase displays, e-mails and text messages, philanthropic activities tied to branding opportunities, and communication through "viral marketing" and by word-of-mouth. Food marketing to children is now a global phenomenon and tends to be pluralistic and integrated, using multiple messages in multiple channels.

RECOMMENDATIONS

RATIONALE

14. The reviews of evidence show a clear rationale for action to be taken by Member States in this area. The need to develop appropriate policy mechanisms was also acknowledged by various Member States during the consultation process for the development of these recommendations. These further support Health Assembly resolutions WHA60.23 and WHA61.14 on prevention and control of noncommunicable diseases and provide a solid rationale for policy development by Member States.

RECOMMENDATION 1. The policy aim should be to reduce the impact on children of marketing of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt.

15. The effectiveness of marketing communications depends on two elements: the media in which the communication message appears and its creative content. The first element deals with the reach, frequency and impact of the message, thus influencing the *exposure* of children to the marketing message. The second element relates to the content, design and execution of the marketing message, influencing the *power* of the marketing communication. The effectiveness of marketing can thus be described as a function of both *exposure* and *power*.

RECOMMENDATION 2. Given that the effectiveness of marketing is a function of exposure and power, the overall policy objective should be to reduce both the exposure of children to, and the power of, marketing of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt.

POLICY DEVELOPMENT

16. Member States can take various approaches to achieve the policy aim and objective, depending on national circumstances and available resources. Member States can adopt a *comprehensive approach* to restricting all marketing to children of foods with a high content of saturated fats, *trans*-fatty acids, free sugars, or salt, which fully eliminates the exposure, and thereby also the power, of that marketing. Alternatively, Member States can start by either addressing exposure or power independently or dealing with aspects of both simultaneously in a *stepwise approach*.

17. Different policy approaches have different potential to achieve the policy aim of reducing the impact on children of marketing of foods with a high content of saturated fats, *trans*-fatty acids, free sugars, or salt. A comprehensive approach has the highest potential to achieve the desired impact.

18. When addressing *exposure*, consideration should be given to when, where, to whom and for what products marketing will, or will not, be permitted. When addressing *power*, consideration should be given to restricting the use of marketing techniques that have a particularly powerful effect. If for example a stepwise approach is chosen, attention should be given to the marketing to which children have greatest exposure, and to the marketing messages that have greatest power.

RECOMMENDATION 3. To achieve the policy aim and objective, Member States should consider different approaches, that is, stepwise or comprehensive, to reduce marketing of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt to children.

19. Effective implementation depends on clear definitions of the policy components. These definitions will determine the potential of the policy to reduce exposure and/or power, and thus impact. Important definitions include the age group for which restrictions shall apply, the communication channels, settings and marketing techniques to be covered, what constitutes marketing to children according to factors such as product, timing, viewing audience, placement and content of the marketing message, as well as what foods are to be covered by marketing restrictions.¹

RECOMMENDATION 4. Governments should set clear definitions for the key components of the policy, thereby allowing for a standard implementation process. The setting of clear definitions would facilitate uniform implementation, irrespective of the implementing body. When setting the key definitions Member States need to identify and address any specific national challenges so as to derive the maximal impact of the policy.

20. Schools, childcare and other educational establishments are privileged institutions acting *in loco parentis*, and nothing that occurs in them should prejudice a child's well-being. Therefore the nutritional well-being of children within schools should be paramount and the foundation stone for children's well-being at this formative age. This is also consistent with the recommendation made in the Global Strategy on Diet, Physical Activity and Health that urges governments to adopt policies to support healthy diets in schools.

RECOMMENDATION 5. Settings where children gather should be free from all forms of marketing of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt. Such settings include, but are not limited to, nurseries, schools, school grounds and pre-school centres, playgrounds, family and child clinics and paediatric services and during any sporting and cultural activities that are held on these premises.

21. Policy on food marketing to children involves a wide range of stakeholders and cuts across several policy sectors. Governments are in the best position to set direction and overall strategy to achieve population-wide public health goals. When governments are engaging with other stakeholders care should be taken to protect the public interest and avoid conflict of interest. Regardless of the policy framework chosen, there should be widespread communication of the policy to all stakeholder groups, including the private sector, civil society, nongovernmental organizations, the media, academic researchers, parents and the wider community.

¹ Member States can choose to distinguish food types in several ways, for example by using national dietary guidelines or definitions set by scientific bodies or nutrient profiling models, or they can base the marketing restrictions on specific categories of foods.

RECOMMENDATION 6. Governments should be the key stakeholders in the development of policy and provide leadership, through a multistakeholder platform, for implementation, monitoring and evaluation. In setting the national policy framework, governments may choose to allocate defined roles to other stakeholders, while protecting the public interest and avoiding conflict of interest.

POLICY IMPLEMENTATION

22. The defined policy may be implemented through a variety of approaches. Statutory regulation is one approach through which implementation and compliance are a legal requirement. Another approach is industry-led self-regulation, which covers whole industry sectors, for example the advertising sector, and can be independent of government regulation. This approach may still be mandated by government in some form such as the setting of targets and monitoring implementation using key indicators. Other approaches include various co-regulatory mechanisms, comprising statutory, self-regulation and/or voluntary industry initiatives which either exist within the framework of a government mandate or are not formally linked. Governments or mandated bodies can also issue or implement guidelines.

23. Member States that restrict all or certain aspects of marketing of foods with a high content of saturated fats, *trans*-fatty acids, free sugars, or salt to children should ensure that restrictions at national level also apply to marketing originating from their territory and reaching other countries (out-flowing). In many countries the effects of marketing coming in from other countries (in-flowing) may be as important as the marketing originating nationally. In these situations action at national level will have to consider not only marketing originating nationally but also marketing that enters the country from beyond their borders, taking into account the international obligations of the Member State concerned. In these situations, effective international collaboration is essential to ensure significant impact of national actions.

24. Independently of any other measures taken for implementation of a national policy, private sector stakeholders should be encouraged to follow marketing practices that are consistent with the policy aim and objective set out in these recommendations and to practise them globally in order to ensure equal consideration to children everywhere and avoid undermining efforts to restrict marketing in countries that receive food marketing from beyond their borders.

25. Civil society, nongovernmental organizations and academic researchers have the potential to contribute to policy implementation through capacity building, advocacy, and technical expertise.

RECOMMENDATION 7. Considering resources, benefits and burdens of all stakeholders involved, Member States should consider the most effective approach to reduce marketing to children of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt. Any approach selected should be set within a framework developed to achieve the policy objective.

RECOMMENDATION 8. Member States should cooperate to put in place the means necessary to reduce the impact of cross-border marketing (in-flowing and out-flowing) of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt to children in order to achieve the highest possible impact of any national policy.

RECOMMENDATION 9. The policy framework should specify enforcement mechanisms and establish systems for their implementation. In this respect, the framework should include clear definitions of sanctions and could include a system for reporting complaints.

POLICY MONITORING AND EVALUATION

26. Monitoring provides a system for collecting and documenting information on whether the policy meets its objectives. Evaluation is likewise important because it measures the impact of the policy aims and objectives. Monitoring and evaluation may need different approaches to ensure effectiveness and avoidance of conflict of interest.

27. The policy framework should include a set of core process and outcome indicators, clearly defined roles and assignment of responsibility for monitoring and evaluation activities and mechanisms to parties that have no conflict of interest. Indicators need to be specific, quantitative and measurable using instruments that are valid and reliable.

28. Monitoring of the policy should use relevant indicators that measure the effect of the policy on its objective (i.e. reducing exposure and power).

29. An example of how to assess a reduction in *exposure* may be to measure the quantity of, or expenditure on, marketing communications to children of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt. This can be done through measuring the number of advertisements directed at children of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt shown on television over a 24-hour period.

30. An example of how to assess a reduction in *power* may be to measure the prevalence of specified techniques used. This can be done through measuring the prevalence of advertisements directed at children of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt using licensed characters or celebrities, or other techniques of special appeal to children, on television over a 24-hour period.

31. Information generated from monitoring can be used: (i) to support enforcement; (ii) publicly to document compliance; (iii) to guide policy refinement and improvement; and (iv) to contribute to policy evaluation.

RECOMMENDATION 10. All policy frameworks should include a monitoring system to ensure compliance with the objectives set out in the national policy, using clearly defined indicators.

32. Evaluation of the policy should use specific indicators that evaluate the effect of the policy on its overall aim (that is, to reduce the impact). The indicators should also evaluate if children are directly or indirectly exposed to marketing messages intended for other audiences or media.

33. An example of how to assess a reduction in the *impact* may be to measure the changes in sales or market share for foods high in saturated fats, *trans*-fatty acids, free sugars, or salt; and measure the changes in children's consumption patterns in response to the policy.

34. Evaluation should ideally use baseline data as the benchmark, with such data being collected as a first step to establish the real policy impact.

RECOMMENDATION 11. The policy frameworks should also include a system to evaluate the impact and effectiveness of the policy on the overall aim, using clearly defined indicators.

RESEARCH

35. Global reviews have shown that most of the available evidence to date comes from high-income countries. Many Member States do not have national data and research that enable them to identify the extent, nature and effects of food marketing to children. This type of research can further inform policy implementation and its enforcement within a national context.

RECOMMENDATION 12. Member States are encouraged to identify existing information on the extent, nature and effects of food marketing to children in their country. They are also encouraged to support further research in this area, especially research focused on implementation and evaluation of policies to reduce the impact on children of marketing of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt.

ANNEX 5

WHO Global Code of Practice on the International Recruitment of Health Personnel¹

Preamble

The Member States of the World Health Organization,

Recalling resolution WHA57.19 in which the World Health Assembly requested the Director-General to develop a voluntary code of practice on the international recruitment of health personnel in consultation with all relevant partners;

Responding to the calls of the Kampala Declaration adopted at the First Global Forum on Human Resources for Health (Kampala, 2–7 March 2008) and the G8 communiqués of 2008 and 2009 encouraging WHO to accelerate the development and adoption of a code of practice;

Conscious of the global shortage of health personnel and recognizing that an adequate and accessible health workforce is fundamental to an integrated and effective health system and for the provision of health services;

Deeply concerned that the severe shortage of health personnel, including highly educated and trained health personnel, in many Member States, constitutes a major threat to the performance of health systems and undermines the ability of these countries to achieve the Millennium Development Goals and other internationally agreed development goals;

Stressing that the WHO global code of practice on the international recruitment of health personnel be a core component of bilateral, national, regional and global responses to the challenges of health personnel migration and health systems strengthening,

THEREFORE

The Member States hereby agree on the following articles which are recommended as a basis for action.

Article 1 – Objectives

The objectives of this Code are:

- (1) to establish and promote voluntary principles and practices for the ethical international recruitment of health personnel, taking into account the rights, obligations and expectations of source countries, destination countries and migrant health personnel;
- (2) to serve as a reference for Member States in establishing or improving the legal and institutional framework required for the international recruitment of health personnel;

¹ See resolution WHA63.16.

(3) to provide guidance that may be used where appropriate in the formulation and implementation of bilateral agreements and other international legal instruments;

(4) to facilitate and promote international discussion and advance cooperation on matters related to the ethical international recruitment of health personnel as part of strengthening health systems, with a particular focus on the situation of developing countries.

Article 2 – Nature and scope

2.1 The Code is voluntary. Member States and other stakeholders are strongly encouraged to use the Code.

2.2 The Code is global in scope and is intended as a guide for Member States, working together with stakeholders such as health personnel, recruiters, employers, health-professional organizations, relevant subregional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel.

2.3 The Code provides ethical principles applicable to the international recruitment of health personnel in a manner that strengthens the health systems of developing countries, countries with economies in transition and small island states.

Article 3 – Guiding principles

3.1 The health of all people is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and states. Governments have a responsibility for the health of their people, which can be fulfilled only by the provision of adequate health and social measures. Member States should take the Code into account when developing their national health policies and cooperating with each other, as appropriate.

3.2 Addressing present and expected shortages in the health workforce is crucial to protecting global health. International migration of health personnel can make a sound contribution to the development and strengthening of health systems, if recruitment is properly managed. However, the setting of voluntary international principles and the coordination of national policies on international health personnel recruitment are desirable in order to advance frameworks to equitably strengthen health systems worldwide, to mitigate the negative effects of health personnel migration on the health systems of developing countries and to safeguard the rights of health personnel.

3.3 The specific needs and special circumstances of countries, especially those developing countries and countries with economies in transition that are particularly vulnerable to health workforce shortages and/or have limited capacity to implement the recommendations of this Code, should be considered. Developed countries should, to the extent possible, provide technical and financial assistance to developing countries and countries with economies in transition aimed at strengthening health systems, including health personnel development.

3.4 Member States should take into account the right to the highest attainable standard of health of the populations of source countries, individual rights of health personnel to leave any country in accordance with applicable laws, in order to mitigate the negative effects and maximize the positive effects of migration on the health systems of the source countries. However, nothing in this Code should be interpreted as limiting the freedom of health personnel, in accordance with applicable laws, to migrate to countries that wish to admit and employ them.

3.5 International recruitment of health personnel should be conducted in accordance with the principles of transparency, fairness and promotion of sustainability of health systems in developing

countries. Member States, in conformity with national legislation and applicable international legal instruments to which they are a party, should promote and respect fair labour practices for all health personnel. All aspects of the employment and treatment of migrant health personnel should be without unlawful distinction of any kind.

3.6 Member States should strive, to the extent possible, to create a sustainable health workforce and work towards establishing effective health workforce planning, education and training, and retention strategies that will reduce their need to recruit migrant health personnel. Policies and measures to strengthen the health workforce should be appropriate for the specific conditions of each country and should be integrated within national development programmes.

3.7 Effective gathering of national and international data, research and sharing of information on international recruitment of health personnel are needed to achieve the objectives of this Code.

3.8 Member States should facilitate circular migration of health personnel, so that skills and knowledge can be achieved to the benefit of both source and destination countries.

Article 4 – Responsibilities, rights and recruitment practices

4.1 Health personnel, health professional organizations, professional councils and recruiters should seek to cooperate fully with regulators, national and local authorities in the interests of patients, health systems, and of society in general.

4.2 Recruiters and employers should, to the extent possible, be aware of and consider the outstanding legal responsibility of health personnel to the health system of their own country such as a fair and reasonable contract of service and not seek to recruit them. Health personnel should be open and transparent about any contractual obligations they may have.

4.3 Member States and other stakeholders should recognize that ethical international recruitment practices provide health personnel with the opportunity to assess the benefits and risks associated with employment positions and to make timely and informed decisions.

4.4 Member States should, to the extent possible under applicable laws, ensure that recruiters and employers observe fair and just recruitment and contractual practices in the employment of migrant health personnel and that migrant health personnel are not subject to illegal or fraudulent conduct. Migrant health personnel should be hired, promoted and remunerated based on objective criteria, such as levels of qualification, years of experience and degrees of professional responsibility on the basis of equality of treatment with the domestically trained health workforce. Recruiters and employers should provide migrant health personnel with relevant and accurate information about all health personnel positions that they are offered.

4.5 Member States should ensure that, subject to applicable laws, including relevant international legal instruments to which they are a party, migrant health personnel enjoy the same legal rights and responsibilities as the domestically trained health workforce in all terms of employment and conditions of work.

4.6 Member States and other stakeholders should take measures to ensure that migrant health personnel enjoy opportunities and incentives to strengthen their professional education, qualifications and career progression, on the basis of equal treatment with the domestically trained health workforce subject to applicable laws. All migrant health personnel should be offered appropriate induction and orientation programmes that enable them to operate safely and effectively within the health system of the destination country.

4.7 Recruiters and employers should understand that the Code applies equally to those recruited to work on a temporary or permanent basis.

Article 5 – Health workforce development and health systems sustainability

5.1 In accordance with the guiding principle as stated in Article 3 of this Code, the health systems of both source and destination countries should derive benefits from the international migration of health personnel. Destination countries are encouraged to collaborate with source countries to sustain and promote health human resource development and training as appropriate. Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers.

5.2 Member States should use this Code as a guide when entering into bilateral, and/or regional and/or multilateral arrangements, to promote international cooperation and coordination on international recruitment of health personnel. Such arrangements should take into account the needs of developing countries and countries with economies in transition through the adoption of appropriate measures. Such measures may include the provision of effective and appropriate technical assistance, support for health personnel retention, social and professional recognition of health personnel, support for training in source countries that is appropriate for the disease profile of such countries, twinning of health facilities, support for capacity building in the development of appropriate regulatory frameworks, access to specialized training, technology and skills transfers, and the support of return migration, whether temporary or permanent.

5.3 Member States should recognize the value both to their health systems and to health personnel themselves of professional exchanges between countries and of opportunities to work and train abroad. Member States in both source and destination countries should encourage and support health personnel to utilize work experience gained abroad for the benefit of their home country.

5.4 As the health workforce is central to sustainable health systems, Member States should take effective measures to educate, retain and sustain a health workforce that is appropriate for the specific conditions of each country, including areas of greatest need, and is built upon an evidence-based health workforce plan. All Member States should strive to meet their health personnel needs with their own human resources for health, as far as possible.

5.5 Member States should consider strengthening educational institutions to scale up the training of health personnel and developing innovative curricula to address current health needs. Member States should undertake steps to ensure that appropriate training takes place in the public and private sectors.

5.6 Member States should consider adopting and implementing effective measures aimed at strengthening health systems, continuous monitoring of the health labour market, and coordination among all stakeholders in order to develop and retain a sustainable health workforce responsive to their population's health needs. Member States should adopt a multisectoral approach to addressing these issues in national health and development policies.

5.7 Member States should consider adopting measures to address the geographical maldistribution of health workers and to support their retention in underserved areas, such as through the application of education measures, financial incentives, regulatory measures, social and professional support.

Article 6 – Data gathering and research

6.1 Member States should recognize that the formulation of effective policies and plans on the health workforce requires a sound evidence base.

6.2 Taking into account characteristics of national health systems, Member States are encouraged to establish or strengthen and maintain, as appropriate, health personnel information systems, including health personnel migration, and its impact on health systems. Member States are encouraged to collect, analyse and translate data into effective health workforce policies and planning.

6.3 Member States are encouraged to establish or strengthen research programmes in the field of health personnel migration and coordinate such research programmes through partnerships at the national, subnational, regional and international levels.

6.4 WHO, in collaboration with relevant international organizations and Member States, is encouraged to ensure, as much as possible, that comparable and reliable data are generated and collected pursuant to paragraphs 6.2 and 6.3 for ongoing monitoring, analysis and policy formulation.

Article 7 – Information exchange

7.1 Member States are encouraged to, as appropriate and subject to national law, promote the establishment or strengthening of information exchange on international health personnel migration and health systems, nationally and internationally, through public agencies, academic and research institutions, health professional organizations, and subregional, regional and international organizations, whether governmental or nongovernmental.

7.2 In order to promote and facilitate the exchange of information that is relevant to this Code, each Member State should, to the extent possible:

- (a) progressively establish and maintain an updated database of laws and regulations related to health personnel recruitment and migration and, as appropriate, information about their implementation;
- (b) progressively establish and maintain updated data from health personnel information systems in accordance with Article 6.2; and
- (c) provide data collected pursuant to subparagraphs (a) and (b) above to the WHO Secretariat every three years, beginning with an initial data report within two years after the adoption of the Code by the Health Assembly.

7.3 For purposes of international communication, each Member State should, as appropriate, designate a national authority responsible for the exchange of information regarding health personnel migration and the implementation of the Code. Member States so designating such an authority, should inform WHO. The designated national authority should be authorized to communicate directly or, as provided by national law or regulations, with designated national authorities of other Member States and with the WHO Secretariat and other regional and international organizations concerned, and to submit reports and other information to the WHO Secretariat pursuant to subparagraph 7.2(c) and Article 9.1.

7.4 A register of designated national authorities pursuant to paragraph 7.3 above shall be established, maintained and published by WHO.

Article 8 – Implementation of the Code

8.1 Member States are encouraged to publicize and implement the Code in collaboration with all stakeholders as stipulated in Article 2.2, in accordance with national and subnational responsibilities.

8.2 Member States are encouraged to incorporate the Code into applicable laws and policies.

8.3 Member States are encouraged to consult, as appropriate, with all stakeholders as stipulated in Article 2.2 in decision-making processes and involve them in other activities related to the international recruitment of health personnel.

8.4 All stakeholders referred to in Article 2.2 should strive to work individually and collectively to achieve the objectives of this Code. All stakeholders should observe this Code, irrespective of the capacity of others to observe the Code. Recruiters and employers should cooperate fully in the observance of the Code and promote the guiding principles expressed by the Code, irrespective of a Member State's ability to implement the Code.

8.5 Member States should, to the extent possible, and according to legal responsibilities, working with relevant stakeholders, maintain a record, updated at regular intervals, of all recruiters authorized by competent authorities to operate within their jurisdiction.

8.6 Member States should, to the extent possible, encourage and promote good practices among recruitment agencies by only using those agencies that comply with the guiding principles of the Code.

8.7 Member States are encouraged to observe and assess the magnitude of active international recruitment of health personnel from countries facing critical shortage of health personnel, and assess the scope and impact of circular migration.

Article 9 – Monitoring and institutional arrangements

9.1 Member States should periodically report the measures taken, results achieved, difficulties encountered and lessons learnt in a single report in conjunction with the provisions of Article 7.2(c).

9.2 The Director-General shall keep under review the implementation of this Code, on the basis of periodic reports received from designated national authorities pursuant to Articles 7.3 and 9.1 and other competent sources, and periodically report to the World Health Assembly on the effectiveness of the Code in achieving its stated objectives and suggestions for its improvement. This report would be submitted in conjunction with Article 7.2(c).

9.3 The Director-General shall:

- (a) support the information exchange system and the network of designated national authorities specified in Article 7;
- (b) develop guidelines and make recommendations on practices and procedures and such joint programmes and measures as specified by the Code; and
- (c) maintain liaison with the United Nations, the International Labour Organization, the International Organization for Migration, and other competent regional and international organizations as well as concerned nongovernmental organizations to support implementation of the Code.

9.4 WHO Secretariat may consider reports from stakeholders as stipulated in Article 2.2 on activities related to the implementation of the Code.

9.5 The World Health Assembly should periodically review the relevance and effectiveness of the Code. The Code should be considered a dynamic text that should be brought up to date as required.

Article 10 – Partnerships, technical collaboration and financial support

10.1 Member States and other stakeholders should collaborate directly or through competent international bodies to strengthen their capacity to implement the objectives of the Code.

10.2 International organizations, international donor agencies, financial and development institutions, and other relevant organizations are encouraged to provide their technical and financial support to assist the implementation of this Code and support health system strengthening in developing countries and countries with economies in transition that are experiencing critical health workforce shortages and/or have limited capacity to implement the objectives of this Code. Such organizations and other entities should be encouraged to cooperate with countries facing critical shortages of health workers and undertake to ensure that funds provided for disease-specific interventions are used to strengthen health systems capacity, including health personnel development.

10.3 Member States either on their own or via their engagement with national and regional organizations, donor organizations and other relevant bodies should be encouraged to provide technical assistance and financial support to developing countries or countries with economies in transition, aiming at strengthening health systems capacity, including health personnel development in those countries.

ANNEX 6

Interventions to prevent or treat birth defects¹

[A63/10 – 1 April 2010]

Preconception care	Pregnancy care	Newborn infant and child care
<p>Family planning</p> <ul style="list-style-type: none"> Introducing women to the concept of reproductive choice Reducing the total number of children born with a birth defect Reducing the proportion of mothers of advanced maternal age, which reduces the birth prevalence of autosomal trisomies, particularly Down syndrome Allowing women with affected children the option of not having further children <p>Preconception screening and counselling</p> <ul style="list-style-type: none"> Using family history taken in primary health care facilities to identify individuals at risk of having affected children Undertaking carrier screening for common recessive disorders (e.g. thalassaemia and sickle cell disorders) <p>Optimizing women's diet before and throughout pregnancy</p> <ul style="list-style-type: none"> Promoting the use of salt fortified with iodine to prevent iodine deficiency disorder Promoting the use of a staple food fortified with folic acid and of supplementary multivitamins with folic acid to prevent neural tube defects and other malformations Promoting avoidance of alcohol, tobacco and cocaine Promoting an adequate general diet (e.g. with sufficient protein, calories, iron) Ensure adequate general diet (protein, calories, iron) <p>Preventing and treating teratogen-induced infections before and throughout pregnancy</p> <p>Such infections include:</p> <ul style="list-style-type: none"> syphilis rubella (67 countries do not have national rubella immunization programmes) <p>Optimizing preconception maternal health and treatment for</p> <ul style="list-style-type: none"> Insulin-dependent diabetics Women on treatment for epilepsy Women on treatment with warfarin 	<p>Antenatal screening for:</p> <ul style="list-style-type: none"> Rhesus status Syphilis Individuals at risk of having children with birth defects using a family history Down syndrome (advanced maternal age; maternal serum screening; early ultrasound scanning) Neural tube defects (maternal serum screening) Major malformations (ultrasound fetal anomaly scanning (18+ weeks gestation)) Carriers of common recessive disorders (e.g. thalassaemia and sickle cell disorders) <p>Prenatal diagnosis</p> <ul style="list-style-type: none"> Ultrasound Amniocentesis Chorionic villus biopsy <p>Fetal treatment for</p> <ul style="list-style-type: none"> Syphilis Fetal anaemia with intrauterine transfusion 	<p>Newborn infant examination</p> <ul style="list-style-type: none"> Trained examiner clinically examining all newborn infants for birth defects <p>Newborn infant screening</p> <ul style="list-style-type: none"> Congenital hypothyroidism Phenylketonuria Cystic fibrosis Others, as dictated by each country's needs and circumstances <p>Medical treatment</p> <p>Examples:</p> <ul style="list-style-type: none"> Neonatal jaundice in glucose-6-phosphate dehydrogenase deficiency and Rhesus incompatibility Treatment and care for children with blood disorders such as sickle-cell disorder, thalassaemia, etc. Treatment of some inborn errors of metabolism Care of children with cystic fibrosis <p>Surgery</p> <p>Examples include the correction of:</p> <ul style="list-style-type: none"> Simple congenital heart defects Cleft lip and palate Club foot Congenital cataracts <p>Rehabilitation and palliative care</p> <p>As appropriate</p>

¹ See resolution WHA63.17.

ANNEX 7¹

WHO strategy on research for health

[A63/22 – 25 March 2010]

CONTEXT AND RATIONALE

Research, global health and WHO

1. This strategy sets out how to strengthen WHO's involvement in research for health and the consequent role of research within WHO. It recognizes that research is central to progress in global health and identifies ways in which the Secretariat can work with Member States and partners to harness science, technology and broader knowledge in order to produce research evidence and tools for improving health outcomes.
2. In all Member States increasing demands are being placed on research to provide opportunities for resolving current and emerging health problems. In meeting the challenge of resolving priority problems across the spectrum of public health – whether it be tackling diseases of poverty, responding to the global epidemiological transition to chronic diseases, ensuring that mothers have access to safe delivery practices, or preparing for global threats to health security – research is indispensable.
3. In a global environment of competing demands for limited resources, it is especially important that health policies and practices should be informed by the best research evidence. The fundamental importance of research for WHO is identified in Article 2 of the Constitution of the World Health Organization; further, in the Eleventh General Programme of Work 2006–2015, the harnessing of knowledge, science and technology is highlighted as one of seven priority areas.
4. The Eleventh General Programme provides a global health agenda for the Organization, its Member States and the international community; however, although the value of research is widely recognized, exploiting research optimally to resolve priority health problems is not a straightforward matter. The complex nature of the health problems confronting societies, the rapid advances in knowledge and technologies related to health, the shifting expectations and concerns of the public in respect of research, and changes in the organization and management of research within and across countries, are among the many factors that must be taken into account.
5. Importantly, much progress has been made in recent decades. In parallel to the growing importance attached to health globally, attention is increasingly being focused by the broader research community on the health problems of the poor and disadvantaged. Significant research efforts, involving public–private partnerships and other innovative mechanisms, are being concentrated on neglected diseases in order to stimulate the development of vaccines, drugs and diagnostics where market forces alone are insufficient. Likewise, shared vulnerability to global infectious threats such as severe acute respiratory syndrome and avian influenza has mobilized global research efforts in support of enhancing capacity for preparedness and response in the areas of surveillance, rapid diagnostics and development of vaccines and medicines.

¹ See resolution WHA63.21.

6. In addition to this progress, there is growing awareness that research systems are not responding optimally to the diverse demands that they face. Investments in health research are insufficient; further, they are not appropriately directed towards tackling priority health problems. In addition, when complex challenges are being met, such as tackling food insecurity or the effects of climate change, there has been a failure to draw on resources available for research in other sectors. Low-income countries are faced with a diverse range of donor-driven research agendas that often weaken national priorities, and many countries are facing significant challenges in training and retaining researchers.

7. Work in support of the ethical review and public accountability of research is not keeping pace with best practices. The opportunity of creating a shared framework for storing and sharing research data, tools and materials has not been seized with the same energy in the area of health as it has in other scientific fields, and policy-makers are neither contributing to research priorities nor using evidence to inform their decisions.

8. In view of the rapid changes taking place in public health and research, there is an urgent need for a systematic and comprehensive approach to organizing and managing research for health. This strategy seeks to define WHO's role in satisfying that need.

WHO's role in research for health

9. The Eleventh General Programme of Work identifies six core functions of WHO, one of which is: "shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge". The other five functions – which involve providing leadership, setting norms and standards, articulating evidence-based policy options, providing technical support and monitoring the health situation – all require strong research competencies among the staff of the Secretariat.

Definitions and concepts

10. The term "research for health" reflects the fact that improving health outcomes requires the involvement of many sectors and disciplines. As identified in the work of the Global Forum for Health Research, research of this type seeks to perform the functions of understanding the impact on health of policies, programmes, processes, actions or events originating in any sector; of assisting in developing interventions that will help to prevent or mitigate that impact; and of contributing to the achievement of the Millennium Development Goals, health equity and better health for all. Research for health covers the full spectrum of research, which spans the following five generic areas of activity:

- measuring the magnitude and distribution of the health problem¹
- understanding the diverse causes or the determinants of the problem, whether they are due to biological, behavioural, social or environmental factors
- developing solutions or interventions that will help to prevent or mitigate the problem
- implementing or delivering solutions through policies and programmes
- evaluating the impact of these solutions on the level and distribution of the problem.

¹ The term "health problem" is used in this strategy to refer to a major cause of ill-health or health inequity, whether actual or prospective. It includes the following: diseases such as HIV/AIDS or mental illness; risks to health such as obesity, poverty or climate change; and obstacles to effective systems performance, such as unsafe care or inequitable financing of health services.

11. The strategy also draws on a systematic framework for health research systems, as presented in the *Bulletin of the World Health Organization* in 2003.¹ In this framework four core functions are defined for research systems, namely: stewardship; financing; creating and sustaining the research workforce and infrastructure; and producing, synthesizing and using knowledge.

Development of the draft WHO strategy on research for health

12. In resolution WHA60.15 the Health Assembly requested the Director-General to develop a strategy for the management and organization of research activities within WHO. This represents an opportunity for the Organization to: (1) review and revitalize the role of research within WHO; (2) improve its support to Member States in building health research capacity; (3) strengthen its advocacy of the importance of research for health; and (4) better communicate its involvement in research for health.

13. The WHO strategy on research for health was developed by the Secretariat by means of an 18 month consultative process. The process involved staff at headquarters and regional and country offices, as well as key partners (including funding bodies, the private sector, the research community and nongovernmental organizations). An external reference group provided extensive comments on successive drafts of the strategy, as did the Advisory Committee on Health Research.

14. Aware that a realistic, forward-looking strategy requires an informed understanding of past successes and failures and current realities, development of the strategy was also informed, inter alia, by:

- a historical review of research at WHO
- previous Health Assembly resolutions on research
- a comprehensive survey and analysis of current research activities across the 34 departments of the Secretariat and the special research programmes and centres.²

As requested by the Health Assembly in resolution WHA61.21, attention was given to ensuring that the development of WHO's research strategy reflected, as appropriate, the global strategy and plan of action on public health, innovation and intellectual property.

WHO STRATEGY ON RESEARCH FOR HEALTH

Research in the service of health

15. This comprehensive, Organization-wide strategy will underpin all the Secretariat's work.

16. The **vision** for the strategy is that decisions and actions to improve health and enhance health equity are grounded in evidence from research. The **mission** of the strategy is for the Secretariat, Member States and partners to work together to harness science, technology and broader knowledge in order to produce research-based evidence and tools for improving health.

¹ *Bulletin of the World Health Organization* 2003, **81**(11): 815–820.

² "Overview of Research at WHO 2006/07", available online at http://www.who.int/rpc/research_strategy/en/index.html.

17. The strategy reflects WHO's diverse roles and responsibilities in respect of research for health: the Organization works to provide stewardship and advocacy, convene funders, catalyse change, and build capacity; and it acts as a communicator, producer and user of research.

18. The strategy calls for changes in order to improve capacity to access and make use of existing research findings; and in order to better understand, and mobilize support for, the research needed for improving health and health outcomes.

19. In the strategy it is also recognized that achieving health goals requires a more effective involvement on the part of WHO with the broader global research community and funders of research, and with sectors other than health.

Guiding principles

20. The WHO strategy on research for health is grounded in three principles that will guide achievement of the goals and the realization of the vision.

Quality – WHO commits itself to high-quality research that is ethical, expertly reviewed, efficient, effective, accessible to all, and carefully monitored and evaluated.

Impact – WHO gives priority to research and innovation that has the greatest potential to improve global health security, accelerate health-related development, redress health inequities and help to attain the Millennium Development Goals.

Inclusiveness – The Secretariat undertakes to work in partnership with Member States and stakeholders, to take a multisectoral approach to research for health, and to support and promote the participation of communities and civil society in the research process.

Goals

21. Five interrelated goals have been defined to enable WHO to achieve the vision of the strategy.

- **Organization** – this involves the strengthening of the research culture across WHO
- **Priorities** – this concerns the reinforcement of research (at national, regional and global levels, and within WHO) in response to priority health needs
- **Capacity** – this relates to the provision of support to the strengthening of national systems for health research
- **Standards** – this concerns the promotion of good practice in research, drawing on WHO's core function of setting norms and standards
- **Translation** – this involves the strengthening of links between the policy, practice and products of research.

22. WHO needs to show it can lead by example, which is why the **Organization** goal is the foundation of the strategy. It is an essential part of the other four goals, defining the Secretariat's interactions with Member States and partners in the activities for achieving each goal.

23. The current global health situation is complex and characterized by an array of new and existing health challenges, many of which call for greater efforts in the area of research. Given the competing

needs of the different areas of research, it is essential not only to mobilize sufficient resources for research but also to ensure their careful distribution. WHO's roles, in respect of the **priorities** goal, are as follows: to offer assistance in identifying, in a timely manner, priorities for research for health, especially those that can benefit the poorest members of society; and to mobilize all stakeholders in order to provide an effective response.

24. Strengthening Member States' national systems research in support of health – the **capacity** goal – is essential for improving health delivery, health security and health outcomes. Efforts to attain this goal need to focus on institutional capacity building in order to develop the necessary human resources and physical infrastructure for conducting research. Attention must also be directed towards satisfying the need for policy leadership, financing, and standards for research.

25. No country is self-sufficient in its research capacity, so Member States need to be able to share research outputs. Effective and equitable sharing requires internationally agreed norms and standards for research; with this in mind, the **standards** goal concerns the promotion of good practice in research by means of work to establish agreements on good practices, scientific benchmarks, ethical guidelines and accountability mechanisms. The achievement of this goal is essential for winning public support and confidence.

26. Finally, if the ultimate objective of research for health is to improve health outcomes, the generation of knowledge alone is not sufficient: knowledge has to be harnessed in order to inform policy and practice and develop products. In establishing the **translation** goal, WHO aims to facilitate a more productive interface between researchers and those who use evidence, including policy-makers and practitioners at national, regional and global levels.

27. A summary of the outputs generated in achieving each goal is shown in Table 1.

Table 1. Summary of outputs for the WHO strategy on research for health

<p>Biennial report to the Health Assembly, indicating:</p> <ul style="list-style-type: none"> – progress in implementing and evaluating the research strategy and related expenditures (Organization goal)¹ – global progress in strengthening national health research systems as measured using standardized indicators at the country level (priorities goal) – the adaptation/adoption of norms and standards by Member States and the results of audits examining adherence to them (standards goal)
<p>Biennial report to the Director-General, indicating:</p> <ul style="list-style-type: none"> – the processes, coverage and impact of: <ul style="list-style-type: none"> • WHO's revised recruitment procedures and incentives, and the Organization's training programme on research and research use (Organization goal) • WHO's ethical review committees (standards goal) • WHO's guideline review committee (standards goal) • WHO's programme review committee (Organization goal)

¹ The goal to which the output is most closely related is indicated in brackets.

<ul style="list-style-type: none"> – implementation of WHO's code of good research practice, including the results of periodic audits of WHO research practices (Organization goal) – whether, and if so, by what means, improvements have been made in the mechanisms by which WHO acts as a research partner (Organization goal) – research agendas with which WHO is directly involved, or for which it is acting as an advocate, their continued appropriateness for WHO, and their coherence as a whole within WHO (priorities goal) – WHO's advocacy efforts related to national health research systems (capacity goal) – the number of country cooperation strategies that involve multi-partner technical cooperation to support the strengthening of national health research systems (capacity goal) – alignments across the efforts to build research capacity with which WHO is affiliated (capacity goal)
<p>Norms and standards</p> <ul style="list-style-type: none"> – Norms and standards for research (standards goal) – WHO's code of good research practice (Organization goal) – Guidelines for building national capacity in respect of the four main functions of national health research systems (capacity goal)
<p>Public reports and resources</p> <ul style="list-style-type: none"> – Public report every four years (co-published with partners) on global research priorities, comprehensive research agendas for each priority, and the alignment of financial and human resources with these agendas (priorities goal) – Biennial public report on research at WHO (Organization goal) – Public report on WHO's position on open access to research outputs and on mechanisms to record research outputs that are not currently being recorded elsewhere (translation goal) – Reports on lessons learnt from efforts to build research capacity, including evaluations of the effectiveness of particular approaches using standardized indicators (capacity goal) – Reports on the lessons learnt from using different interventions to support policy and practice in Member States, based on the best available research evidence, using different models of technology transfer and of research-translation platforms (translation goal) – Publicly accessible research registry for all research with which WHO is affiliated (Organization goal) – Publicly accessible clinical trials registries (standards goal) – Up-to-date, optimally packaged evidence summaries that are context-sensitive, and guidance in areas of public health need (translation goal)

ORGANIZATION GOAL

28. The Organization goal is to strengthen the research culture across WHO.

The challenge

29. Consultations undertaken in developing the strategy generated a clear message, from both within the Organization and beyond, that WHO needs to undertake a major change in behaviour in order to keep pace with the evolving research environment and communicate better the nature of its own research activities.

30. The internal obstacles that WHO must overcome, identified during the consultation process, include:

- the lack of a common, well-articulated vision for research for health
- the fragmented and uncoordinated nature of research activities across the Organization
- the inconsistent use of evidence in establishing policies, programmes, and global norms and standards
- the absence of standards of research practice for staff producing and using research
- the insufficient number of staff with appropriate research skills and an adequate understanding of research
- the lack of a dedicated budget to support research activities
- the bureaucratic and financial arrangements that many research partners find awkward
- the lack of sufficient incentives and encouragement to ensure that staff are involved and that they improve their competencies in research or research-related activities.

31. The activities related to the **Organization** goal will tackle these obstacles by improving research practices in accordance with the strategy's three principles: quality, impact and inclusiveness. The aim is for WHO to have effective governance mechanisms for supporting the production, dissemination and use of research evidence both within the Organization and beyond.

32. WHO's guidance and programmes will therefore need to be informed by the best available research evidence. Further, the research activities with which WHO is affiliated will need to be aligned with a code of good research practice. A general understanding will also be required, both within WHO and beyond, of the central role played by research evidence in the Organization's activities and of the broader role of the Organization in research.

Actions to achieve the goal

33. Working with Member States and partners, the Secretariat will:

- (a) establish appropriate structures for keeping abreast of latest developments in knowledge management, interaction with the global research community, and leading, managing and coordinating research within WHO, and for maintaining accountability for such research; and secure the resources needed to support the implementation and evaluation of this strategy;
- (b) develop and implement a WHO code of good research practice for those of its staff involved with research and the use of evidence;

- (c) strengthen existing mechanisms for good research practice, including:
 - (i) ethical and peer review structures and procedures;
 - (ii) the appropriate use of evidence to inform the development of guidelines;
 - (iii) the regular review of core policies and programmes in the light of new evidence;
- (d) enhance the research-related competencies of relevant professional staff by applying designated criteria in their recruitment, by providing on-the-job training, and by identifying incentives for good research performance that are linked to regular evaluations;
- (e) improve the management and coordination of WHO-affiliated research, and develop a publicly accessible repository for all such research in order to improve access to the knowledge thus derived;
- (f) improve performance in research partnerships by:
 - (i) reviewing financial, legal and administrative processes for working with partners; and
 - (ii) seeking contacts with a broader network of partners across all sectors that influence research for health;
- (g) improve communication – both throughout the Secretariat and with Member States, partners and the public – regarding WHO's involvement in research, submitting regular reports, including reports on the monitoring and evaluation of this strategy.

Expected results

34. Achievement of this goal should produce the results described below:

- WHO Secretariat staff who understand, value and use evidence better in planning, implementing and evaluating programmes and activities, and in setting norms and standards
- WHO-supported research that systematically adheres to the Organization's code of good research practice and is subject to scientific and, where appropriate, ethical review; guidelines and recommendations that are systematically evidence-based, and articles that are systematically peer reviewed
- clear communication of WHO's role in research and of the role of research within WHO
- general recognition that WHO is a credible, evidence-based organization; a leader in supporting or performing high-quality research; a champion of the need for research; and an effective partner in facilitating high-quality research at global, regional and country levels
- the allocation by WHO of sufficient resources to support core functions necessary for the implementation of the strategy
- translation of the most up-to-date knowledge and evidence into advice, norms and guidelines by the WHO Secretariat.

PRIORITIES GOAL

35. The priorities goal is to champion research that addresses priority health needs.

The challenge

36. Each country has a responsibility to develop its own agenda for research in order to respond to the health needs important to its population within its own social, political and environmental setting. In addition, there are present and emerging health challenges that must be met through national and cross-country research. Such challenges include preparing for and responding to pandemics, gaining an understanding of the impact of climate change and developing new drugs, vaccines and diagnostics for widespread diseases such as malaria, HIV/AIDS and tuberculosis.

37. However, agreeing on research priorities for improving health and taking action to pursue them remains a significant challenge. The obstacles responsible for this include imbalances in national research priorities, the historical inequity in the distribution of global research funding (with only 10% of financing for global health research allocated to health problems that affect 90% of the world's population) and the difficulty of making the case for financing research in the face of competing priorities.

38. In recent years, however, the mobilization in support of the Millennium Development Goals and the recognition that good health is a foundation of development, have encouraged an impressive upsurge in research for global health. Diverse stakeholders – including governments, civil society, philanthropic bodies and industry – have mobilized significant resources through numerous public-private partnerships and multilateral research initiatives. The Health Assembly has adopted the global strategy and the agreed parts of the action plan on public health, innovation and intellectual property rights. This instrument places emphasis on identifying research and development priorities for tackling diseases of poverty, and identifies the relevant global financing mechanisms.

39. National research capacity needs to be aligned with a complex global environment and the existence of diverse sources of funding for research.

40. Throughout the consultations for this strategy, the Secretariat, working with Member States, donors and key stakeholders, was consistently requested to make greater use of its convening power in order to draw attention to research for health in neglected areas, and to build consensus and catalyse new actions in support of such research.

41. When research capacity is low, WHO is expected to promote collaboration across countries and within regions in order to create a more effective research effort in response to shared health challenges. In such circumstances, as in the past, WHO will develop special programmes for research in order to stimulate activity, leverage resources and encourage innovation.

Actions to achieve the goal

42. Working with Member States and partners, the Secretariat will:

- (a) ensure that mechanisms are in place for synthesizing data on gaps in research relating to current health- and health system-related challenges at national and global levels;
- (b) convene high-level consultations to identify, and build consensus on, the priorities to include in global agendas for research for health and the financing necessary for implementing the relevant activities;

- (c) produce a report every four years on global priorities for research with an assessment of the alignment of financial and human resources with research agendas;
- (d) develop comprehensive research agendas for specific priority areas and develop plans for mobilizing the necessary resources;
- (e) advocate support for research areas, research groups and institutions that are working to close critical gaps in research agendas in support of global research priorities; and
- (f) improve the coherence of WHO's research activities by establishing mechanisms for the periodic review of the portfolio of research agendas, including decision criteria to guide decision-making concerning the initiation, adjustment and winding down of programmes.

Expected results

43. Achievement of this goal should produce the results described below:

- greater awareness of, and action on, research priorities at a national level
- greater awareness of, and action on, research priorities at regional and global levels
- improved cooperation and coordination among research funders and other key partners to align global resources so that priority needs for research for health can be met
- more robust agendas for research on specific priority areas that are facilitated by WHO, and greater coherence and clarity concerning WHO's involvement therein.

CAPACITY GOAL

44. The capacity goal is to support the development of robust national health research systems.

The challenge

45. Robust and vibrant national health research systems in all countries are critical for accelerating the achievement of national and global health goals, namely: better health, improved health equity, and fairer, safer and more efficient health systems.

46. There has long been an understanding of the basic prerequisites for health research systems, namely: clear national research policy, leadership, a capable research workforce, adequate financing, priority-setting mechanisms, strong regulatory frameworks and structures (including ethical oversight), well-equipped research institutions, effective information systems and dissemination plans. Nevertheless, in many countries, particularly low- and middle-income countries, health research systems remain seriously under-resourced and poorly managed, and health information systems are often absent or inadequate.

47. Such deficiencies are evidence of the following: an insufficient appreciation at a political level of the value of research in accelerating health improvement and development; the general absence of coordinated and sustained efforts to build national research systems; and the inability of fragmented research efforts driven by external actors to align themselves with strategies for strengthening national capacities.

48. In consultations for the development of this strategy, the strengthening of national systems for health research and the monitoring of their performance were deemed top priorities for WHO, as part of its key role of providing greater and more visible leadership.

49. WHO needs to foster collaboration between researchers and research institutions in low-, middle- and high-income countries through regional and global networks.

50. The coordination of activities to build research capacity will also need to be improved throughout the Organization. Such activities will need to be aligned with the priorities identified in Member States, and WHO will need to encourage a similar alignment on the part of other actors.

Actions to achieve the goal

51. Working with Member States and partners, the Secretariat will:

- (a) strengthen its advocacy in support of both research and the development of robust national systems for research for health;
- (b) develop tools and guidelines for strengthening national capacity in the four main functions of national systems for research for health (stewardship; financing; creating and sustaining resources; and producing, synthesizing and using knowledge);
- (c) continue to promote the development of the comprehensive systems for health information that are necessary in order to support national research priorities;
- (d) develop and use standardized indicators in order to: enable self-reporting of the performance of national health research systems; monitor global progress in strengthening capacity; and evaluate the effectiveness of particular approaches to capacity building;
- (e) facilitate technical assistance to support the strengthening of national systems for health research;
- (f) build institutional capacity to report and share good practice, by facilitating regional and global networks, and with the involvement of WHO collaborating centres;
- (g) maximize the impact of efforts in Member States to build research capacity by improving the alignment of such initiatives across WHO's research programmes and activities.

Expected results

52. Achievement of this goal should produce the results described below:

- greater investment in research for health by countries and other actors
- the existence in all countries, especially low- and middle-income ones, of national research strategies that articulate clear research priorities, credible capacity-building programmes, and explicit terms of engagement for external stakeholders
- the alignment of external stakeholders' research investments with national research strategies
- the development and use of WHO guidelines on research capacity-building, including indicators for measuring progress

- progress reports on national research capacity and activities made every two or three years by the Secretariat through WHO's governing bodies and information databases
- networks of researchers and communities of practice that actively exchange experiences and identify good practices in the area of capacity building for research
- higher-quality, better-coordinated research activities through the alignment with country needs of WHO's efforts to build national research capacity.

STANDARDS GOAL

53. The standards goal is to promote good research practice.

The challenge

54. Setting international norms, standards and guidelines is one of WHO's core functions, and an activity that the Organization is uniquely placed to perform. The norms, standards and guidelines related to research are applied to govern, manage and improve the quality of research; to address inefficiencies in the research process; and to improve access to information. They are essential to maintaining public trust, confidence and participation in research.

55. Member States, international organizations, stakeholders and the public expect WHO to do more to promote best practices in research. There is also an increasing demand for more accountability and transparency in the conduct of research.

56. One challenge is to develop a methodology that is rigorous, systematic and transparent, with clear criteria for deciding when WHO should work on a new standard or guideline, how that standard or guideline should be developed, and which stakeholders need to be involved. Such a methodology will need to accommodate differences in social and cultural contexts while protecting the rights and welfare of all participants in the research process.

57. Another challenge is to improve the implementation of, and compliance with, existing research standards. The standards concerned include those related to ethics, ethics review committees and clinical trial registration, and laboratory biosafety and biosecurity. Although WHO cannot enforce compliance with standards (except, where applicable, for its own staff), it has an influential role to play in accelerating progress towards the development and adoption of global standards for best practices in research.

58. There is also a need to establish acceptable criteria for the use, for example in the development of guidelines, of evidence that could not be generated using conventional research approaches such as randomized trials.

Actions to achieve the goal

59. Working with Member States and partners, the Secretariat will:

- (a) develop a systematic method for selecting, developing, adopting and evaluating new standards and norms in line with priorities in research for health;
- (b) develop, in line with the guiding principles of this strategy, norms and standards for best practice in the management of research to cover, for example: ethical and expert review and the

accreditation of ethical review committees; the reporting of research findings; the sharing of research data, tools and materials; the registration of clinical trials; and the use of evidence in the development of policy, practice and products;

(c) continue to facilitate the development of, and set standards for, publicly accessible registries of clinical trials; and

(d) engage in technical cooperation with Member States in order to enable them to adapt and implement norms and standards for research, and monitor subsequent adherence and compliance.

Expected results

60. Achievement of this goal should produce the results described below:

- strengthened public support for and trust in health and medical research
- implementation by WHO of an improved method for selecting, developing, adopting and evaluating norms and standards related to research
- improved quality, efficiency, transparency, accountability and equity in the research process as a result of greater awareness, acceptance and implementation of standards for the management of research, and compliance therewith
- improved acceptance of, and compliance with, ethical principles in the conduct of research; and the establishment of standards for accreditation of ethics committees
- adoption by all countries of the registration of clinical trials according to WHO standards.

TRANSLATION GOAL

61. The translation goal is to strengthen links between research, policy and practice.

The challenge

62. Consultations for the development of this strategy revealed both the extent to which evidence fails to inform policy and practice, and the degree to which the research agenda fails to respond to policy needs. Referred to as “research translation”, the dynamic interface that links research with policy, practice and product development is increasingly seen as a priority area for research. In addition, new and improved methods are required for communicating health information and evidence effectively to different target audiences across multiple sectors, levels and languages.

63. A significant barrier to achieving this goal is the global inequality of access – in respect of research – to data, tools, materials and literature, which may arise due to restrictions placed on their reuse through the application of copyright and intellectual property. There are various standards that exist for information systems and interoperability but few that are consistently applied in the area of public health informatics.

64. WHO, with its reach into countries and contacts with researchers, policy-makers, practitioners and civil society, can play a unique role in advocating for greater resources in support of research into this knowledge interface. WHO needs to facilitate access to quality data, consolidated evidence and

authoritative health information and guidelines in order to support the dialogue between policy-makers and public-health implementers. One WHO-led initiative, the Evidence-Informed Policy Networks initiative, is beginning to provide an approach to meeting these challenges.

65. WHO has contributed to improvements in this area through initiatives such as the Health InterNetwork Access to Research Initiative and the Reproductive Health Library, through the creation of the International Clinical Trials Registry Platform, and by allowing public access to the Organization's databases. However, access to research continues to be limited by a range of factors – including the lack of standards in health informatics, and problems of affordability and language – and the Organization needs to do more to involve itself fully with the open access movement.

Actions to achieve the goal

66. Working with Member States and partners, the Secretariat will:

- (a) identify promising translation activities through evaluation, and promote their use to support decision-making based on the best available research evidence;
- (b) promote the use of effective models of technology transfer and the evaluation of promising models in order to support the timely creation of new products and services in Member States;
- (c) promote and evaluate platforms for translating research in support of translation capacity and evidence-informed policy-making in Member States;
- (d) work towards the creation of, and compliance with, international standards on health informatics for research;
- (e) develop, strengthen and evaluate mechanisms for the systematic elaboration of evidence summaries and guidance for citizens, patients, clinicians, managers and policy-makers in Member States, ensuring that such mechanisms are adapted for the target audience and regularly updated, and that their impact is evaluated;
- (f) systematically analyse barriers and encourage the creation of mechanisms to promote greater access to research results, or the enhancement of existing ones;
- (g) adopt and articulate a WHO position on open access to research outputs; and advocate for the following: databanks, repositories and other mechanisms for maximizing the availability of health-related research findings that are freely accessible in the public domain.

Expected results

67. Achievement of this goal should produce the results described below:

- a situation in which decision-makers act as informed consumers of research, using available evidence and knowledge more effectively, creating evidence-informed policy and translating that policy into practice and products
- establishment of institutional mechanisms for recording, and sharing lessons learnt from, research focused on the demand for research and the way evidence is used in policy and practice at country level

- performance of research activities in order to understand the translation of evidence into policy and practice and the recognition of the important contribution that such research can make to research for health
- creation and broad application of internationally agreed standards for the collection, storing and sharing of health informatics/tools and data
- establishment of comprehensive repositories that include WHO's research literature that are well stocked, regularly updated and well used
- development of existing repositories of systematic reviews, or the establishment of new ones, in order to meet the priority health needs of low- and middle-income countries
- easy access on the part of both producers and users of research to reliable, relevant, appropriate and timely information that is provided in a format and language they understand
- researchers who are more responsive to the demand side, including to the health-related research questions of policy-makers (in health and other sectors), practitioners and civil society
- a more prominent role played by WHO in identifying effective health interventions and strategies, and in promoting their implementation in Member States.

IMPLEMENTATION

68. The Eleventh General Programme of Work 2006–2015 provides the WHO Secretariat, Member States and the international community with a global health agenda that stems from an analysis of the current global health situation. After setting the broader global health agenda, the General Programme of Work then describes WHO's comparative advantages, its core functions, the main challenges it faces and its priorities for the future. These priorities are further developed in the six-year Medium term strategic plan 2008–2013, which defines 13 strategic objectives for the Secretariat and Member States.

69. The Secretariat will work with Member States and partners to plan the implementation of the WHO strategy on research for health in support of the Medium-term strategic plan within the Eleventh General Programme of Work.

70. For the regional offices, the WHO strategy on research for health sets out a framework to guide the formulation of future regional research strategies.

71. The implementation plans will be realistic and will define clear roles, responsibilities, resources required, outcomes and impacts within a timetable as indicated in the evaluation framework. The plans will build on the research activities already under way in more than 34 WHO programmes, alliances and networks in support of the strategy's goals.

72. A plan for implementing the strategy will be incorporated into the Organization's operational arrangements and workplans and, in discussion with Member States, integrated into country cooperation strategies.

73. A report on progress will be submitted to the Health Assembly on a biennial basis, with the first report scheduled for 2012.

CRITICAL ISSUES IN IMPLEMENTATION

Governance within WHO

74. In order to ensure successful implementation of the strategy, the Organization will need to develop appropriate mechanisms for improving strategic and operational efficiency across the WHO's portfolio of research activities. One possible mechanism would involve the creation of thematic groups working across the Organization in areas such as research capacity building and knowledge management. Such new mechanisms will be complemented by a thorough review and, where appropriate, revitalization of existing mechanisms. This will include a review of the role of technical and advisory committees, and a possible reconsideration of the role of ACHR, both globally and in the regions.

Working with partners

75. In implementing the strategy, the Secretariat will also need to collaborate effectively with the dedicated research partnerships to which WHO is linked, but which are characterized by independent governance. The partnerships concerned include the following: the Alliance for Health Policy and Systems Research; the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction; the Initiative for Vaccine Research; the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases; the Council on Health Research for Development; and the Global Forum for Health Research. During the implementation process, the value of providing such partnerships with a governance structure that is more aligned, or even shared, with that of the WHO research strategy will be examined; modifications will be made to existing relationships in line with the actions for achieving specific goals.

76. In addition to collaborating with existing partnerships, in implementing the new strategy WHO is expected to work more effectively with key research partners, including industry, civil society, foundations and academia.

Staffing

77. The strategy's success will be largely contingent upon the efforts of WHO technical staff across the Organization. The organizational goal of the strategy provides several recommendations related to improving the research competencies of WHO staff through strengthened support for research, continued learning and changes to the recruitment and evaluation processes as appropriate. Particular attention will need to be paid to identifying the appropriate response for staff at country level. Once implemented, the code of good research practice will provide a common approach and a set of minimum standards for the research activities of staff wherever they are working. Staff will also be needed for ensuring the effective performance of functions related to cross-cutting thematic groups, ethical and guidelines review, standard setting and communications.

Funding

78. About 80% of the budget for conducting or commissioning research directed through programmes at headquarters (about US\$ 200 million per biennium) is financed through voluntary contributions. The WHO strategy on research for health aims to improve the quality of research outputs by influencing the way in which these resources are spent, rather than by increasing the level of financing.

79. Nevertheless, implementation of this strategy (and of the global strategy and plan of action on public health, innovation and intellectual property) requires an adequately resourced central secretariat

responsible for, among other things, cross-cutting themes, communications and evaluation. The funding of the secretariat's activities will require core budget support as funds from either the specific research activities of WHO departments or from voluntary contributions are unlikely to be available. The amount of money to support the secretariat function is modest, representing less than 5% of total research expenditure per biennium. Resources for these core functions will be fully budgeted in the Programme budget 2010–2011.

EVALUATION

Overview

80. Evaluation is an integral part of the WHO strategy on research for health, and an evaluation framework has been developed in order to provide an impact-focused approach for assessing the achievement of the strategy's vision, mission and goals. A report providing details of the framework is available upon request.

81. More specifically, the framework will provide an approach for:

- monitoring implementation of the elements of the research strategy
- evaluating the impact of the changes brought about by implementation of the strategy.

82. The evaluation framework for the WHO strategy on research for health covers both its implementation and its constituent elements, namely, the principles, goals, actions and expected results.

83. The framework has been developed in line with best practices in evaluation; it will:

- be focused on the shared goals and activities of the Secretariat, Member States and partners, as outlined by the research strategy
- give a balanced picture of progress towards realizing the shared vision for the Secretariat, Member States and partners
- be efficient, utilizing existing indicators and mechanisms wherever possible to minimize the reporting burdens of the Secretariat, Member States and partners.

Structure of the evaluation framework

84. The evaluation framework organizes the elements of the WHO strategy on research for health, into inputs/activities, outputs, outcomes and impacts (known as a "logic model"); it also defines indicators to be tracked for each of these components (see below).

85. Although the strategy's ultimate impact should be improvements in health and health equity (such as those articulated in the Millennium Development Goals), identifying the contribution of research for health generally, and of the strategy in particular, in achieving wider health impacts represents a major challenge. Given the difficulties associated with predicting circumstances in which case studies of health impact would be feasible, the evaluation framework model focuses on impacts that can be evaluated prospectively. The framework can be expanded further to include new indicators of health impact after the implementation phase has started.

Monitoring progress

86. One or more indicators have been developed for each input/activity, output, outcome and impact. Table 2 provides a list of indicators, which is for illustrative purposes only.¹

Table 2. List of indicators

Impact <ul style="list-style-type: none"> – Percentage of priority health needs for which up-to-date systematic reviews of the research literature were made available within one year of the need being identified (priorities goal) – Percentage of a random sample of clinicians in Member States who achieve a nationally defined target for adherence to select high-quality, locally applicable recommendations (translation goal)
Outcomes <ul style="list-style-type: none"> – Percentage, within a random sample, of WHO's guidelines that are aligned with the best available research evidence (Organization goal) – Percentage of Member States (specifically, their principal delegates at the Health Assembly) that report general satisfaction with the nature of technical cooperation received in support of their national health research system (capacity goal)
Outputs <ul style="list-style-type: none"> – Biennial report on progress in strengthening national health research systems submitted to the Health Assembly (capacity goal) – Norms and standards for research published (standards goal)
Inputs/activities <ul style="list-style-type: none"> – At least 5% of WHO's combined core and voluntary budgets allocated in support of research at WHO, including dedicated funds for the implementation and evaluation of the research strategy in the current biennium (Organization goal) – Percentage of Member States whose priority-setting processes have been drawn on to inform priorities in research for health (priorities goal)

87. Although indicators available through existing mechanisms have been identified wherever appropriate, new indicators to improve monitoring of selected elements of the research for health agenda have been proposed, where necessary. These new indicators generally concern outcome- and impact-related measures, which are directly linked to the goals of the strategy. A full description of these indicators and proposed mechanisms for monitoring implementation is presented separately in the full evaluation framework.

88. As suggested by the grouping of outputs in Table 1 above, the proposed reporting structures are of four types: governance-related indicators (to be compiled into a biennial report to the Health Assembly); management-related indicators (to be compiled into a biennial report to the Director-General); indicators for norms and standards and indicators for other public reports and resources. All reports will be publicly available on WHO's web site.

¹ A full list of indicators will be provided in the document presenting the full evaluation framework.

ANNEX 8¹

WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation

[A63/24 – 25 March 2010]

PREAMBLE

1. As the Director-General's report to the Executive Board at its Seventy-ninth session pointed out,² human organ transplantation began with a series of experimental studies at the beginning of the twentieth century. The report drew attention to some of the major clinical and scientific advances in the field since Alexis Carrel was awarded the Nobel Prize in 1912 for his pioneering work. Surgical transplantation of human organs from deceased, as well as living, donors to sick and dying patients began after the Second World War. Over the past 50 years, the transplantation of human organs, tissues and cells has become a worldwide practice which has extended, and greatly enhanced the quality of, hundreds of thousands of lives. Continuous improvements in medical technology, particularly in relation to organ and tissue rejection, have led to an increase in the demand for organs and tissues, which has always exceeded supply despite substantial expansion in deceased organ donation as well as greater reliance on donation from living persons in recent years.
2. The shortage of available organs has not only prompted many countries to develop procedures and systems to increase supply but has also stimulated commercial traffic in human organs, particularly from living donors who are unrelated to recipients. The evidence of such commerce, along with the related traffic in human beings, has become clearer in recent decades. Moreover, the growing ease of international communication and travel has led many patients to travel abroad to medical centres that advertise their ability to perform transplants and to supply donor organs for a single, inclusive charge.
3. Resolutions WHA40.13 and WHA42.5 first expressed the Health Assembly's concern over commercial trade in organs and the need for global standards for transplantation. Based on a process of consultation undertaken by the Secretariat, the Health Assembly then endorsed the WHO Guiding Principles on Human Organ Transplantation in resolution WHA44.25. Over the past 17 years the Guiding Principles have greatly influenced professional codes and practices as well as legislation around the world. In the light of changes in practices and attitudes regarding organ and tissue transplantation, the Fifty-seventh World Health Assembly in resolution WHA57.18 requested the Director-General, inter alia, "to continue examining and collecting global data on the practices, safety, quality, efficacy and epidemiology of allogeneic transplantation and on ethical issues, including living donation, in order to update the Guiding Principles on Human Organ Transplantation".
4. The following Guiding Principles are intended to provide an orderly, ethical and acceptable framework for the acquisition and transplantation of human cells, tissues and organs for therapeutic purposes. Each jurisdiction will determine the means of implementing the Guiding Principles. They preserve the essential points of the 1991 version while incorporating new provisions in response to

¹ See resolution WHA63.22.

² Document EB79/8.

current trends in transplantation, particularly organ transplants from living donors and the increasing use of human cells and tissues. The Guiding Principles do not apply to transplantation of gametes, ovarian or testicular tissue, or embryos for reproductive purposes, or to blood or blood constituents collected for transfusion purposes.

Cells, tissues and organs may be removed from deceased and living persons for the purpose of transplantation, only in accordance with the following Guiding Principles.

Guiding Principle 1

Cells, tissues and organs may be removed from the bodies of deceased persons for the purpose of transplantation if:

- (a) any consent required by law is obtained, and
- (b) there is no reason to believe that the deceased person objected to such removal.

Commentary on Guiding Principle 1

Consent is the ethical cornerstone of all medical interventions. National authorities are responsible for defining the process of obtaining and recording consent for cell, tissue and organ donation in the light of international ethical standards, the manner in which organ procurement is organized in their country, and the practical role of consent as a safeguard against abuses and safety breaches.

Whether consent to procure organs and tissues from deceased persons is “explicit” or “presumed” depends upon each country’s social, medical and cultural traditions, including the manner in which families are involved in decision-making about health care generally. Under both systems any valid indication of deceased persons’ opposition to posthumous removal of their cells, tissues or organs will prevent such removal.

Under a regime of explicit consent – sometimes referred to as “opting in” – cells, tissues or organs may be removed from a deceased person if the person had expressly consented to such removal during his or her lifetime; depending upon domestic law, such consent may be made orally or recorded on a donor card, driver’s license or identity card or in the medical record or a donor registry. When the deceased has neither consented nor clearly expressed opposition to organ removal, permission should be obtained from a legally specified surrogate, usually a family member.

The alternative, presumed consent system – termed “opting (or contracting) out” – permits material to be removed from the body of a deceased person for transplantation and, in some countries, for anatomical study or research, unless the person had expressed his or her opposition before death by filing an objection with an identified office, or an informed party reports that the deceased definitely voiced an objection to donation. Given the ethical importance of consent, such a system should ensure that people are fully informed about the policy and are provided with an easy means to opt out.

Although expressed consent is not required in an opting-out system before removal of the cells, tissues or organs of a deceased person who had not objected while still alive, procurement programmes may be reluctant to proceed if the relatives personally oppose the donation; likewise, in opting-in systems, programmes typically seek permission from the family even when the deceased gave pre-mortem consent. Programmes are more able to rely on the deceased’s explicit or presumed consent, without seeking further permission from family members, when the public’s understanding and acceptance of the process of donating cells, tissues and organs is deep-seated and unambiguous.

Even when permission is not sought from relatives, donor programmes need to review the deceased's medical and behavioural history with family members who knew him or her well, since accurate information about donors helps to increase the safety of transplantation.

For tissue donation, which entails slightly less challenging time constraints, it is recommended always to seek the approval of the next of kin. An important point to be addressed is the manner in which the appearance of the deceased's body will be restored after the tissues are removed.

Guiding Principle 2

Physicians determining that a potential donor has died should not be directly involved in cell, tissue or organ removal from the donor or subsequent transplantation procedures; nor should they be responsible for the care of any intended recipient of such cells, tissues and organs.

Commentary on Guiding Principle 2

This Principle is designed to avoid the conflict of interest that would arise were the physician or physicians determining the death of a potential donor to be responsible in addition for the care of other patients whose welfare depended on cells, tissues or organs transplanted from that donor.

National authorities will set out the legal standards for determining that death has occurred and specify how the criteria and process for determining death will be formulated and applied.

Guiding Principle 3

Donation from deceased persons should be developed to its maximum therapeutic potential, but adult living persons may donate organs as permitted by domestic regulations. In general living donors should be genetically, legally or emotionally related to their recipients.

Live donations are acceptable when the donor's informed and voluntary consent is obtained, when professional care of donors is ensured and follow-up is well organized, and when selection criteria for donors are scrupulously applied and monitored. Live donors should be informed of the probable risks, benefits and consequences of donation in a complete and understandable fashion; they should be legally competent and capable of weighing the information; and they should be acting willingly, free of any undue influence or coercion.

Commentary on Guiding Principle 3

The Principle emphasizes the importance both of taking the legal and logistical steps needed to develop deceased donor programmes where these do not exist and of making existing programmes as effective and efficient as possible.

While favouring the maximal development of transplant programmes that avoid the inherent risks to live donors, the Principle also sets forth basic conditions for live donation. A genetic relationship between donor and recipient may be therapeutically advantageous and can provide reassurance that the donor is motivated by genuine concern for the recipient, as can a legal relationship (such as that between spouses). Many altruistic donations also originate from emotionally related

donors, though the strength of a claimed connection may be difficult to evaluate. Donations by unrelated donors have been a source of concern, though some such cases are unexceptionable, such as in hematopoietic stem cell transplantation (where a wide donor pool is therapeutically advisable) or when an exchange of kidneys is made because the donors are not immunologically well matched with the recipients to whom they are related.

With live donation, particularly by unrelated donors, psychosocial evaluation is needed to guard against coercion of the donor or the commercialism banned by Principle 5. The national health authority should ensure that the evaluation is carried out by an appropriately qualified, independent party. By assessing the donor's motivation and the donor's and recipient's expectations regarding outcomes, such evaluations may help identify – and avert – donations that are forced or are actually paid transactions.

The Principle underscores the necessity of genuine and well-informed choice, which requires full, objective, and locally relevant information and excludes vulnerable persons who are incapable of fulfilling the requirements for voluntary and knowledgeable consent. Voluntary consent also implies that adequate provisions exist for withdrawal of consent up until medical interventions on the recipient have reached the point where the recipient would be in acute danger if the transplant did not proceed. This should be communicated at the time of consent.

Finally, this Principle stresses the importance of protecting the health of living donors during the process of selection, donation, and necessary aftercare to ensure that the potential untoward consequences of the donation are unlikely to disadvantage the remainder of the donor's life. Care for the donor should match care for the recipient, and health authorities have the same responsibility for the welfare of both.

Guiding Principle 4

No cells, tissues or organs should be removed from the body of a living minor for the purpose of transplantation other than narrow exceptions allowed under national law. Specific measures should be in place to protect the minor and, wherever possible the minor's assent should be obtained before donation. What is applicable to minors also applies to any legally incompetent person.

Commentary on Guiding Principle 4

This Principle states a general prohibition on the removal of cells, tissues or organs from legal minors for transplantation. The major exceptions that may be authorized are familial donation of regenerative cells (when a therapeutically comparable adult donor is not available) and kidney transplants between identical twins (where avoiding immunosuppression represents a benefit to the recipient adequate to justify the exception, in the absence of a genetic disorder that could adversely affect the donor in the future).

While the permission of the parent(s) or the legal guardian for organ removal is usually sufficient, they may have a conflict of interest if they are responsible for the welfare of the intended recipient. In such cases, review and approval by an independent body, such as a court or other competent authority, should be required. In any event, a minor's objection to making a donation should prevail over the permission provided by any other party. The professional counselling provided to potential living donors in order to assess, and when needed, address any pressure in the decision to donate, is especially important for minor donors.

Guiding Principle 5

Cells, tissues and organs should only be donated freely, without any monetary payment or other reward of monetary value. Purchasing, or offering to purchase, cells, tissues or organs for transplantation, or their sale by living persons or by the next of kin for deceased persons, should be banned.

The prohibition on sale or purchase of cells, tissues and organs does not preclude reimbursing reasonable and verifiable expenses incurred by the donor, including loss of income, or paying the costs of recovering, processing, preserving and supplying human cells, tissues or organs for transplantation.

Commentary on Guiding Principle 5

Payment for cells, tissues and organs is likely to take unfair advantage of the poorest and most vulnerable groups, undermines altruistic donation, and leads to profiteering and human trafficking. Such payment conveys the idea that some persons lack dignity, that they are mere objects to be used by others.

Besides preventing trafficking in human materials, this Principle aims to affirm the special merit of donating human materials to save and enhance life. However, it allows for circumstances where it is customary to provide donors with tokens of gratitude that cannot be assigned a value in monetary terms. National law should ensure that any gifts or rewards are not, in fact, disguised forms of payment for donated cells, tissues or organs. Incentives in the form of “rewards” with monetary value that can be transferred to third parties are not different from monetary payments.

While the worst abuses involve living organ donors, dangers also arise when payments for cells, tissues and organs are made to next of kin of deceased persons, to vendors or brokers, or to institutions (such as mortuaries) having charge of dead bodies. Financial returns to such parties should be forbidden.

This Principle permits compensation for the costs of making donations (including medical expenses and lost earnings for live donors), lest they operate as a disincentive to donation. The need to cover legitimate costs of procurement and of ensuring the safety, quality and efficacy of human cell and tissue products and organs for transplantation is also accepted as long as the human body and its parts as such are not a source of financial gain.

Incentives that encompass essential items which donors would otherwise be unable to afford, such as medical care or health insurance coverage, raise concerns. Access to the highest attainable standard of health is a fundamental right, not something to be purchased in exchange for body parts. However, free periodic medical assessments related to the donation and insurance for death or complications that arise from the donation may legitimately be provided to living donors.

Health authorities should promote donation motivated by the need of the recipient and the benefit for the community. Any measures to encourage donation should respect the dignity of the donor and foster societal recognition of the altruistic nature of cell, tissue and organ donation. In any event, all practices to encourage the procurement of cells, tissues and organs for transplantation should be defined explicitly by health authorities in a transparent fashion.

National legal frameworks should address each country’s particular circumstances because the risks to donors and recipients vary. Each jurisdiction will determine the details and method of the prohibitions it will use, including sanctions which may encompass joint action with other countries in

the region. The ban on paying for cells, tissues and organs should apply to all individuals, including transplant recipients who attempt to circumvent domestic regulations by travelling to locales where prohibitions on commercialization are not enforced.

Guiding Principle 6

Promotion of altruistic donation of human cells, tissues or organs by means of advertisement or public appeal may be undertaken in accordance with domestic regulation.

Advertising the need for or availability of cells, tissues or organs, with a view to offering or seeking payment to individuals for their cells, tissues or organs, or, to the next of kin, where the individual is deceased, should be prohibited. Brokering that involves payment to such individuals or to third parties should also be prohibited.

Commentary on Guiding Principle 6

This Principle does not affect general advertisements or public appeals to encourage altruistic donation of human cells, tissues or organs, provided that they do not subvert legally established systems of organ allocation. Instead, it aims to prohibit commercial solicitations, which include offering to pay individuals, the next of kin of deceased persons, or other parties in possession (such as undertakers), for cells, tissues or organs; it targets brokers and other intermediaries as well as direct purchasers.

Guiding Principle 7

Physicians and other health professionals should not engage in transplantation procedures, and health insurers and other payers should not cover such procedures, if the cells, tissues or organs concerned have been obtained through exploitation or coercion of, or payment to, the donor or the next of kin of a deceased donor.

Commentary on Guiding Principle 7

Health care professionals should only proceed with the removal, intermediate management or implantation of cells, tissues or organs when donations are unpaid and truly voluntary. (In the case of live donors, a psychosocial evaluation of the donor is usually indicated, as described in Guiding Principle 3). Failing to ensure that the person consenting to the donation has not been paid, coerced or exploited breaches professional obligations and should be sanctioned by the relevant professional organizations and government licensing or regulatory authorities.

Physicians and health-care facilities should also not refer patients to transplant facilities in their own or other countries that make use of cells, tissues or organs obtained through payments to donors, their families or other vendors or brokers; nor may they seek or accept payment for doing so. Post-transplant care may be provided to patients who have undergone transplantation at such facilities, but physicians who decline to provide such care should not face professional sanctions for such refusals, provided that they refer such patients elsewhere.

Health insurers and other payers should reinforce adherence to high ethical standards by refusing to pay for transplants that violate the Guiding Principles.

Guiding Principle 8

All health-care facilities and professionals involved in cell, tissue or organ procurement and transplantation procedures should be prohibited from receiving any payment that exceeds the justifiable fee for the services rendered.

Commentary on Guiding Principle 8

This provision reinforces Guiding Principles 5 and 7 by forbidding profiteering in cell, tissue and organ recovery and implantation. Health authorities should monitor the fees charged for transplantation services to ensure that they are not disguised charges for the cells, tissues or organs themselves. All persons and facilities involved should be accountable for all payments for transplantation services. A medical or other health care practitioner uncertain whether a fee is justifiable should seek the opinion of an appropriate licensing or disciplinary authority before proposing or levying the fee. Fees charged for similar services may be used as a reference.

Guiding Principle 9

The allocation of organs, cells and tissues should be guided by clinical criteria and ethical norms, not financial or other considerations. Allocation rules, defined by appropriately constituted committees, should be equitable, externally justified, and transparent.

Commentary on Guiding Principle 9

Where donation rates do not meet clinical demand, allocation criteria should be defined at national or subregional level by a committee that includes experts in the relevant medical specialties, bioethics and public health. Such multidisciplinaryity is important to ensure that allocation takes into account not only medical factors but also community values and general ethical rules. The criteria for distributing cells, tissues and organs should accord with human rights and, in particular, should not be based on a recipient's gender, race, religion, or economic condition.

This principle implies that the cost of transplantation and follow-up, including immunosuppressive treatment where applicable, should be affordable to all patients concerned – that is, no recipient should be excluded solely for financial reasons.

The concept of transparency is not exclusive to the allocation process but is central to all aspects of transplantation (as is discussed in the commentary on Guiding Principle 11, below).

Guiding Principle 10

High-quality, safe and efficacious procedures are essential for donors and recipients alike. The long-term outcomes of cell, tissue and organ donation and transplantation should be assessed for the living donor as well as the recipient in order to document benefit and harm.

The level of safety, efficacy and quality of human cells, tissues and organs for transplantation, as health products of an exceptional nature, must be maintained and optimized on an ongoing basis. This requires implementation of quality systems including traceability and vigilance, with adverse events and reactions reported, both nationally and for exported human products.

Commentary on Guiding Principle 10

Optimizing the outcome of cell, tissue and organ transplantation entails a rules-based process that encompasses clinical interventions and *ex vivo* procedures from donor selection through long-term follow-up. Under the oversight of national health authorities, transplant programmes should monitor both donors and recipients to ensure that they receive appropriate care, including information regarding the transplantation team responsible for their care.

Evaluation of information regarding the long-term risks and benefits is essential to the consent process and for adequately balancing the interests of donors as well as recipients. The benefits to both must outweigh the risks associated with the donation and transplantation. Donors should not be permitted to donate in clinically hopeless situations.

Donation and transplant programmes are encouraged to participate in national and/or international transplant registries. All deviations from accepted processes that could elevate the risk to recipients or donors, as well as any untoward consequences of donation or transplantation, should be reported to and analysed by responsible health authorities.

Transplantation of human material which does not involve maintenance treatment may not require active, long-term follow-up, though traceability should be ensured for the anticipated lifetime of the donor and the recipient. Internationally agreed means of coding to identify tissues and cells used in transplantation are essential for full traceability.

Guiding Principle 11

<p>The organization and execution of donation and transplantation activities, as well as their clinical results, must be transparent and open to scrutiny, while ensuring that the personal anonymity and privacy of donors and recipients are always protected.</p>
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Commentary on Guiding Principle 11

Transparency can be summarized as maintaining public access to regularly updated comprehensive data on processes, in particular allocation, transplant activities and outcomes for both recipients and living donors, as well as data on organization, budgets and funding. Such transparency is not inconsistent with shielding from public access information that could identify individual donors or recipients while still respecting the necessity of traceability recognized in Principle 10. The objective of the system should be not only to maximize the availability of data for scholarly study and governmental oversight but also to identify risks – and facilitate their correction – in order to minimize harm to donors or recipients.

ANNEX 9

Financial and administrative implications for the Secretariat of resolutions adopted by the Health Assembly¹

1. Resolution WHA63.2 Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected result:
5. To reduce the health consequences of emergencies, disasters, crises and conflicts and minimize their social and economic impact.	5.3 Norms and standards developed, capacity built and technical support provided to Member States for assessing needs and for planning and implementing interventions during the transition and recovery phases of conflicts and disasters.
(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 the expected result.	
3. Budgetary implications	
(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).	
US\$ 3 970 000 over the one-year period of the resolution, including staff, travel, training activities, technical assistance, health supplies, security and operational equipment.	
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	3 970 000
(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).	
US\$ 3 970 000 (one year “life-cycle”).	
(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?	
Seventy-five per cent of US\$ 3 970 000 at headquarters, Regional and Jerusalem Office levels.	

¹ This annex reproduces only those documents that accompanied draft resolutions issued during the Health Assembly.

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

Consolidated Appeal Process (CAP) and voluntary contributions. 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 (IASC) health cluster.

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

It will be necessary to sustain beyond May 2010 the actual presence at country level of the national and international staff recruited to implement humanitarian health activities and interventions in the occupied Palestinian territory.

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

One year.

1. Resolution WHA63.14 Marketing of food and non-alcoholic beverages to children**2. Linkage to programme budget**

Strategic objective:

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

Organization-wide expected result:

6.5 Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed and technical support provided to Member States with a high or increasing burden of disease or death associated with unhealthy diets and physical inactivity, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned.

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

The resolution is linked to the above-mentioned expected result together with its indicators, namely, the number of Member States with a multisectoral strategies and plans for healthy diets (indicator 6.5.1) and the number of WHO technical tools that provide support to Member States in promoting healthy diets (indicator 6.5.2). The resolution proposes endorsement of a set of recommendations to reduce the impact of marketing of foods and non-alcoholic beverages to children; it also urges Member States to develop and/or strengthen action to reduce the impact of marketing on children and to monitor the implementation of the recommendations. The resolution requests the Director-General to provide support to Member States in implementing the set of recommendations and in monitoring and evaluating implementation, to support regional networks and cooperate with other international intergovernmental organizations and bodies, civil society and private stakeholders in implementing the recommendations. The resolution also sets out the timing for reporting to the Health Assembly.

3. Budgetary implications

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

The life-cycle of this resolution is estimated at 10 years (2010–2019) covering two periods of medium-term strategic plans. The estimated cost to the Secretariat for implementation of the global strategy over the envisaged 10-year period at headquarters, in the regional offices and in relevant country offices is US\$ 10 million. It is further estimated that 55% of this amount can be subsumed within current and future budgets.

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

A total of US\$ 2 million are needed, of which US\$ 1 million are required for implementing and monitoring the recommendations at the regional and country levels.

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

No.

4. Financial implications

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

Significant efforts will be put into active resource mobilization as one of the priority action areas, particularly at the initial stage of implementation of the resolution.

5. Administrative implications

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

Normative work will largely be performed at headquarters, but implementation and monitoring will also involve the regional offices and relevant country offices.

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

No.

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

Two additional staff will be required at headquarters, one in the professional category and one in the general service category. An expert in food law with regulation expertise will be required for normative development.

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

The time frame will be 2010–2019, with reporting linked to the progress report on the global strategy for the prevention and control of noncommunicable diseases and its associated action plan. The first report will be submitted to the Sixty-fifth World Health Assembly through the Executive Board at its 130th session.

1. Resolution WHA63.19 WHO Strategy on HIV/AIDS for 2011–2015**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.

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

The resolution aims to strengthen activities linked with the following:

- the development of a strategy on HIV/AIDS for 2011–2015 that will guide WHO's work on normative guidance, technical support to countries, strategic information and advocacy to promote the integration of work on HIV/AIDS into broader health and development programmes, with the aim of achieving the health-related Millennium Development Goals;
- the provision of support to countries to scale up comprehensive and integrated HIV/AIDS programmes in order to achieve internationally agreed development goals.

3. Budgetary implications

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

A maximum of US\$ 320 000, including:

- six regional consultations with countries and other stakeholders, making use of already planned meetings and consultation mechanisms (at US\$ 150 000)
- consultations with civil society (at US\$ 70 000)
- consultation with the Strategic and Technical Advisory Committee on HIV/AIDS (at US\$ 70 000)
- consultations with other strategic partners, including other organizations in the United Nations system, donors and development partners (at US\$ 30 000).

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

The full cost of US\$ 320 000 would be incurred during the biennium 2010–2011.

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

Yes.

4. Financial implications

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

Additional funding is expected from voluntary contributions.

5. Administrative implications

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

WHO headquarters will lead the process of strategy development in association with all six regional offices.

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

Yes.

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

No additional staff are required.

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

The broad consultation process will be completed by November 2010, in time for a draft strategy to be submitted for consideration by the Executive Board at its 128th session in January 2011.

1. Resolution WHA63.28 Establishment of a consultative expert working group on research and development: financing and coordination

2. Linkage to programme budget

Strategic objective:

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

Organization-wide expected result:

11.1 Formulation and monitoring of comprehensive national policies on access, quality and use of essential medical products and technologies advocated and supported.

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

The resolution has links with work to facilitate and implement activities for the global strategy and plan of action on public health, innovation and intellectual property.

3. Budgetary implications

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

US\$ 2 250 000. This includes the estimated cost of three meetings at headquarters.

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

Same as 3(a).

- (c) Is the estimated cost noted in (b) included within the existing approved Programme budget for the biennium 2010-2011? No.**

4. Financial implications

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

Currently there are no funds available. Funding will be sought through voluntary contributions provided by Member States.

5. Administrative implications

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

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

No.

(c) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile) One technical officer at P4 level and one programme assistant at G5 level.

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