



WORLD HEALTH ORGANIZATION

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# **SIXTY-THIRD WORLD HEALTH ASSEMBLY**

**GENEVA, 17–21 MAY 2010**

**RESOLUTIONS AND DECISIONS  
ANNEXES**

GENEVA  
2010

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## ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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

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

## **PREFACE**

The Sixty-third World Health Assembly was held at the Palais des Nations, Geneva, from 17 to 21 May 2010, in accordance with the decision of the Executive Board at its 126th session. Its proceedings are issued in three volumes, containing, in addition to other relevant material:

Resolutions and decisions, Annexes – document WHA63/2010/REC/1

Verbatim records of plenary meetings, list of participants – document WHA63/2010/REC/2

Summary records of committees; reports of committees – document WHA63/2010/REC/3

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A63/4	Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits
A63/5 and A63/5 Add.1	Implementation of the International Health Regulations (2005)
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A63/7	Monitoring of the achievement of the health-related Millennium Development Goals
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A63/9	Infant and young child nutrition
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<sup>1</sup> See page ix.

<sup>2</sup> See Annex 9.

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A63/14	Tuberculosis control
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A63/17	Chagas disease: control and elimination
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<sup>1</sup> See Annex 7.

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A63/29	Programme budget 2008–2009: performance assessment
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A63/40	Human resources: annual report
A63/41	Report of the International Civil Service Commission
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A63/44 and A63/44 Corr.1	Partnerships <sup>2</sup>
A63/44 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly

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<sup>1</sup> See Annex 9.

<sup>2</sup> See Annex 1.

- A63/45 Method of work of the governing bodies
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- A63/50 Eleventh General Programme of Work, 2006–2015. Fifth report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-third World Health Assembly
- A63/51 Rev.1 Financial report and audited financial statements for the period 1 January 2008 – 31 December 2009. Second report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-third World Health Assembly
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- A63/53 Amendments to the Financial Regulations and Financial Rules. Seventh report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-third World Health Assembly
- A63/54 Safety and security of staff and premises and the Capital Master Plan: safety and security of staff and premises. Third report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-third World Health Assembly
- A63/55 Safety and security of staff and premises and the Capital Master Plan: the Capital Master Plan. Fourth report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-third World Health Assembly

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<sup>1</sup> See Annex 2.



## LIST OF DOCUMENTS

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A63/56 Rev.1	Report of the External Auditor. Eighth report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-third World Health Assembly
A63/57	Report of the Internal Auditor. Ninth report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-third World Health Assembly
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A63/61	Election of Members entitled to designate a person to serve on the Executive Board
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A63/66	Fifth report of Committee A

### **Information documents**

A63/INF.DOC./1	Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits
A63/INF.DOC./2	International recruitment of health personnel: draft global code of practice
A63/INF.DOC./3	Counterfeit medical products
A63/INF.DOC./4	Voluntary contributions by fund and by donor for the financial period 2008–2009
A63/INF.DOC./5	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan
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A63/INF.DOC./7	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan
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**Diverse**

A63/DIV/1 Rev.1	List of delegates and other participants
A63/DIV/2	Guide for delegates to the World Health Assembly
A63/DIV/3	Decisions and list of resolutions
A63/DIV/4	List of documents
A63/DIV/5	Address by Mrs Ellen Johnson Sirleaf, President of the Republic of Liberia to the Sixty-third World Health Assembly
A63/DIV/6	Address by Mr Ray Chambers, United Nations Secretary-General's Special Envoy for Malaria to the Sixty-third World Health Assembly

## OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

### **President**

Mr M. ZENAIDI (Tunisia)

### **Vice-Presidents**

Dra. M.I. RODRÍGUEZ (El Salvador)

Dr R. SEZIBERA (Rwanda)

Dr R. AKDAĞ (Turkey)

Mrs G.A.A. GIDLOW (Samoa)

Professor MYA OO (Myanmar)

### **Secretary**

Dr M. CHAN, Director-General

### **Committee on Credentials**

The Committee on Credentials was composed of delegates of the following Member States: Angola, Austria, Bangladesh, Eritrea, Israel, Nauru, Nicaragua, Singapore, Somalia, The former Yugoslav Republic of Macedonia, Trinidad and Tobago, and Zambia.

**Chairman:** Dr B. BLAHA (Austria)

**Vice-Chairman:** Mr S.A. ALI (Bangladesh)

**Secretary:** Mr X. DANEY (Legal Officer)

### **General Committee**

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the Chairmen of the main committees, together with delegates of the following Member States: Burkina Faso, Cap Verde, Chad, Chile, China, Cuba, Democratic Republic of the Congo, Estonia,

France, Jamaica, Jordan, Libyan Arab Jamahiriya, Russian Federation, Spain, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, and United States of America.

**Chairman:** Mr M. ZENAIDI (Tunisia)

**Secretary:** Dr M. CHAN, Director-General

### **MAIN COMMITTEES**

Under Rule 35 of the Rules of Procedure of the World Health Assembly, each delegation was entitled to be represented on each main committee by one of its members.

#### **Committee A**

**Chairman:** Dr M. MUGITANI (Japan)

**Vice-Chairmen:** Mr U. SCHOLTEN (Germany) and Dr D. CHIRIBOGA (Ecuador)

**Rapporteur:** Dr P. MISHRA (Nepal)

**Secretary:** Dr Q.M. ISLAM, Director, Making Pregnancy Safer

#### **Committee B**

**Chairman:** Dr W. JAYANTHA (Sri Lanka)

**Vice-Chairmen:** Dr G.J. KOMBA-KONO (Sierra Leone) and Dr N. EL SAYED (Egypt)

**Rapporteur:** Dr A.-P. SANNE (Norway)

**Co-Secretaries:** Dr M. DAYRIT, Director, Human Resources for Health; and Mr C. ONDARI, Coordinator, Medicines Access and Rational Use



## RESOLUTIONS

### **WHA63.1      Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits<sup>1</sup>**

The Sixty-third World Health Assembly,

Having considered the report of the Open-Ended Working Group of Member States on Pandemic Influenza Preparedness: sharing of influenza viruses and access to vaccines and other benefits that met in Geneva on 10–12 May, 2010;<sup>2</sup>

Recalling resolutions WHA60.28 and WHA62.10, which relate to the Pandemic Influenza Preparedness Framework for the Sharing of Influenza Viruses and Access to Vaccines and Other Benefits,<sup>3</sup> as well as resolutions WHA56.19 and WHA59.2 on pandemic influenza preparedness;

Taking note of all experiences and lessons from the pandemic (H1N1) 2009, the ongoing work of the IHR Review Committee, and lessons learnt from the ongoing outbreaks of influenza H5N1;

Recognizing the continued challenge of improving pandemic influenza preparedness, notably to increase: national and global preparedness and response capacities; improved laboratory and surveillance capacity; global influenza vaccine, antivirals and diagnostics production capacity, and access to vaccines, antivirals and diagnostics, particularly in affected and developing countries, and with special attention to least developed countries;

Recognizing the need to implement a fair and transparent, equitable, efficient and effective system for the sharing of viruses and access to vaccines and other benefits on an equal footing;

Recognizing that the solutions to address these challenges involve the implementation of multiple tools, interlinked as necessary, which may include: separate, but complementary Standard Material Transfer Agreements for relevant materials, one within the WHO Network, and one for transfers outside the WHO Network; strengthening support for WHO's Global Pandemic Influenza Action Plan to Increase Vaccine Supply;<sup>4</sup> surveillance capacity building under the International Health Regulations (2005); and ensuring sustainable financing and solidarity mechanisms;

Recognizing the role of industry as an important contributor to addressing the above challenges in a sustainable and predictable manner;

Considering that some of the remaining elements require further consideration, and studies, as necessary, in order to reach final agreement,

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<sup>1</sup> For financial and administrative implications for the Secretariat of this resolution, see document A63/48 Add.1.

<sup>2</sup> Document A63/48.

<sup>3</sup> See document A62/5 Add.1.

<sup>4</sup> Document WHO/IVB/06.13 – WHO/CDS/EPR/GIP/2006.1.

1. REQUESTS the Director-General:
  - (1) to continue to work with Member States and relevant regional economic integration organizations, on the Pandemic Influenza Preparedness Framework for the Sharing of Influenza Viruses and Access to Vaccines and Other Benefits<sup>1</sup> as decided in resolution WHA62.10 and to convene the Open-Ended Working Group before the 128th session of the Executive Board;
  - (2) to undertake technical consultations and studies as necessary in order to support the work of the Open-Ended Working Group in reaching a final agreement;
2. DECIDES that the Open-Ended Working Group shall report through the Executive Board at its 128th session to the Sixty-fourth World Health Assembly.

(Sixth plenary meeting, 19 May 2010 –  
Committee A, first report)

**WHA63.2 Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan<sup>2</sup>**

The Sixty-third World Health Assembly,

Mindful of the basic principle established in the Constitution of WHO, which affirms that the health of all peoples is fundamental to the attainment of peace and security;

Recalling all its previous resolutions on health conditions in the occupied Arab territories;

Recalling resolution EB124.R4, adopted by the Executive Board at its 124th session, on the grave health situation caused by Israeli military operations in the occupied Palestinian territory, particularly in the occupied Gaza Strip;

Taking note of the report of the Director-General on the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan;

Noting with deep concern the findings in the report of the Director-General on the specialized health mission to the Gaza Strip;

Stressing the essential role of UNRWA in providing crucial health and education services in the occupied Palestinian territory, particularly in addressing the emergency needs in the Gaza Strip;

Expressing its concern at the deterioration of economic and health conditions as well as the humanitarian crisis resulting from the continued occupation and the severe restrictions imposed by Israel, the occupying power;

Expressing its deep concern also at the health crisis and rising levels of food insecurity in the occupied Palestinian territory, particularly in the Gaza Strip;

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<sup>1</sup> As contained in document A62/5 Add.1.

<sup>2</sup> For financial and administrative implications for the Secretariat of this resolution, see Annex 9.

Affirming the need to guarantee universal coverage of health services and to preserve the functions of the public health services in the occupied Palestinian territory;

Recognizing that the acute shortage of financial and medical resources in the Palestinian Ministry of Health, which is responsible for running and financing public health services, jeopardizes the access of the Palestinian population to curative and preventive services;

Affirming the right of Palestinian patients and medical staff to have access to the Palestinian health institutions in occupied east Jerusalem;

Deploping the incidents involving lack of respect and protection for Palestinian ambulances and medical personnel by the Israeli army, which have led to casualties among Palestinian medical personnel, as well as the restrictions on their movements imposed by Israel, the occupying power, in violation of international humanitarian law;

Affirming that the blockade is continuing and that the crossing points are not entirely and definitely opened, meaning that the crisis and suffering that started before the Israeli attack on the Strip are continuing, hindering the efforts of the Ministry of Health of the Palestinian Authority to reconstruct the establishments destroyed by the Israeli military operations by the end of 2008 and in 2009;

Expressing deep concern at the grave implications of the wall on the accessibility and quality of medical services received by the Palestinian population in the occupied Palestinian territory, including east Jerusalem;

Expressing deep concern also at the serious implications for pregnant women and patients of restrictions on movement imposed by Israel on Palestinian ambulances and medical personnel,

1. DEMANDS that Israel, the occupying power:

- (1) immediately put an end to the closure of the occupied Palestinian territory, particularly the closure of the crossing points of the occupied Gaza Strip that is causing the serious shortage of medicines and medical supplies therein, and comply in this regard with the provisions of the Israeli Palestinian Agreement on Movement and Access of November 2005;
- (2) abandon its policies and measures that have led to the prevailing dire health conditions and severe food and fuel shortages in the Gaza Strip;
- (3) comply with the Advisory Opinion rendered on 9 July 2004 by the International Court of Justice on the wall which, inter alia, has grave implications for the accessibility and quality of medical services received by the Palestinian population in the occupied Palestinian territory, including east Jerusalem;
- (4) facilitate the access of Palestinian patients and medical staff to the Palestinian health institutions in occupied east Jerusalem and abroad;
- (5) ensure unhindered and safe passage for Palestinian ambulances as well as respect and protection of medical personnel, in compliance with international humanitarian law;
- (6) improve the living and medical conditions of Palestinian detainees, particularly children, women and patients, and provide the detainees who are suffering from serious medical conditions worsening every day with the necessary medical treatment;

(7) facilitate the transit and entry of medicine and medical equipment to the occupied Palestinian territory;

(8) assume its responsibility with regard to the humanitarian needs of the Palestinian people and their daily access to humanitarian aid, including food and medicine, in compliance with international humanitarian law;

(9) halt immediately all its practices, policies and plans, including its policy of closure, that seriously affect the health conditions of civilians under occupation;

(10) respect and facilitate the mandate and work of UNRWA and other international organizations, and ensure the free movement of their staff and aid supplies;

2. URGES Member States and intergovernmental and nongovernmental organizations:

(1) to help overcome the health crisis in the occupied Palestinian territory by providing assistance to the Palestinian people;

(2) to help meet urgent health and humanitarian needs, as well as the important health-related needs for the medium and long term, identified in the report of the Director-General on the specialized health mission to the Gaza Strip;

(3) to call upon the international community to exert pressure on the Government of Israel to lift the siege imposed on the occupied Gaza Strip in order to avoid a serious exacerbation of the humanitarian crisis therein and to help lift the restrictions and obstacles imposed on the Palestinian people including the free movement of people and medical staff in the occupied Palestinian territory, and to bring Israel to respect its legal and moral responsibilities and ensure the full enjoyment of basic human rights for civilian populations in the occupied Palestinian territory, particularly in east Jerusalem;

(4) to remind Israel, the occupying power, to abide by the Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War of 1949, which is applicable to the occupied Palestinian territory including east Jerusalem;

(5) to call upon all international human rights organizations, particularly the International Committee of the Red Cross, to intervene on an urgent and immediate basis vis-à-vis the occupying power, Israel, and compel it to provide adequate medical treatment to Palestinian prisoners and detainees who are suffering from serious medical conditions worsening every day, and urges civil society organizations to exercise pressure on the occupying power, Israel, to save the lives of detainees and ensure the immediate release of critical cases and to provide them with external treatment, and to allow Palestinian women prisoners to receive maternity care services and medical follow up during pregnancy, delivery and postpartum care, and to allow them to give birth in healthy and humanitarian conditions in the presence of their relatives and family members and immediately to release all children detained in Israeli prisons;

(6) to support and assist the Palestinian Ministry of Health in carrying out its duties, including running and financing public health services;

(7) to provide financial and technical support to the Palestinian public health and veterinary services;



3. EXPRESSES deep appreciation to the international donor community for their support of the Palestinian people in different fields, and urges donor countries and international health organizations to continue their efforts to ensure the provision of necessary political and financial support to enable the implementation of the 2008–2010 health plan of the Palestinian Authority and to create a suitable political environment to implement the plan with a view to putting an end to the occupation and establishing the state of Palestine as proposed by the Government of Palestine, which is working seriously to create the proper conditions for its implementation;
4. EXPRESSES its deep appreciation to the Director-General for her efforts to provide necessary assistance to the Palestinian people in the occupied Palestinian territory, including east Jerusalem, and to the Syrian population in the occupied Syrian Golan;
5. REQUESTS the Director-General:
  - (1) to provide support to the Palestinian health and veterinary services including capacity building;
  - (2) to submit a fact-finding report on the health and economic situation in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan;
  - (3) to support the establishment of medical facilities and provide health-related technical assistance to the Syrian population in the occupied Syrian Golan;
  - (4) to continue providing necessary technical assistance in order to meet the health needs of the Palestinian people, including the handicapped and injured;
  - (5) to also provide support to the Palestinian health and veterinary services in preparing for unusual emergencies;
  - (6) to support the development of the health system in the occupied Palestinian territory, including development of human resources;
  - (7) to establish, in cooperation with the International Committee of the Red Cross, an international committee of specialized medical teams to diagnose the serious health conditions of Palestinian prisoners and detainees in Israeli jails and provide them with all necessary and urgent treatment in accordance with relevant international conventions and agreements;
  - (8) to make available the detailed report prepared by the specialized health mission to the Gaza Strip;
  - (9) to report on implementation of this resolution to the Sixty-fourth World Health Assembly.

(Seventh plenary meeting, 20 May 2010 –  
Committee A, second report)

**WHA63.3 Advancing food safety initiatives<sup>1</sup>**

The Sixty-third World Health Assembly,

Having considered the report on food safety;<sup>2</sup>

Recalling resolution WHA53.15 on food safety, which requested the Director-General to put in place a global strategy for the surveillance of foodborne diseases and for the efficient gathering and exchange of information in and between countries;

Recalling resolution WHA55.16 on the global public health response to natural occurrence, accidental release or deliberate use of biological and chemical agents or radionuclear material that affect health, which noted that such agents can be disseminated through food- and water-supply chains;

Noting the endorsement by the Executive Board in 2002 of WHO's global strategy for food safety,<sup>3</sup> which had as its aim the reduction of the health and social burden of foodborne disease;

Noting also, that other food safety-related activities identified in resolutions WHA53.15 and WHA55.16 have been undertaken, including: the revision of the International Health Regulations in 2005; the establishment of the International Food Safety Authorities Network in 2005; the establishment of WHO's Foodborne Disease Burden Epidemiology Reference Group in 2006; and increased participation, particularly by developing countries, in the elaboration of international food safety standards by the Codex Alimentarius Commission;

Recognizing that the Codex Alimentarius Commission presents a unique opportunity for all countries to join the international community in formulating and harmonizing food standards and ensuring their global implementation, and in particular the participation of developing countries in this regard should be encouraged;

Further recognizing the important roles of WHO and FAO in support of the Codex Alimentarius Commission as the international reference point for developments associated with food standards;

Confirming that foodborne disease continues to represent a serious threat to the health of millions of people in the world, particularly those in developing countries with poor nutritional status;

Mindful of the inextricable links between food safety, nutrition and food security, and acknowledging the instrumental role of food safety in eradicating hunger and malnutrition, in particular in low-income and food-deficit countries;

Aware of increasing evidence that many communicable diseases, including emerging zoonoses, are transmitted through food, and that exposure to chemicals and pathogens in the food supply is associated with acute and chronic diseases;

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<sup>1</sup> For financial and administrative implications for the Secretariat of this resolution, see document EB126/2010/REC/1, Annex 7.

<sup>2</sup> Document A63/11.

<sup>3</sup> Document EB109/2002/REC/2, summary record of the fourth meeting.

Acknowledging that climate change could be a factor in the increasing rates of some foodborne diseases, including those of zoonotic origin, owing to the more rapid growth of microorganisms in food and water with higher temperatures, resulting in the emergence of toxins in new geographical areas and possibly in higher levels of toxins or pathogens in food;

Recognizing that the global trade in food is increasing every year, contributing to the risk of spread of pathogens and contaminants across national borders, thereby creating new challenges for food authorities and necessitating more efficient global sharing of food safety information, taking into account that protection of food safety cannot lead to discrimination or a disguised restriction on international trade;

Acknowledging the continuing need for closer collaboration between the health sector and other sectors, and increased action on food safety at the international and national levels, across the full length of the food-production chain, in order to reduce significantly the incidence of foodborne disease;

Noting the continuing need for updated and comprehensive internationally agreed standards and agreements for risk assessments and scientific advice to support measures and interventions to improve the safety and nutritional quality of food;

Recognizing the importance of international agreement on global management of food safety, the application of scientific principles in finding solutions, the efficient exchange of monitoring and surveillance data, and practical experience,

1. URGES Member States:<sup>1</sup>

(1) to continue to establish and maintain the activities and measures elaborated in resolutions WHA53.15 on food safety and WHA55.16 on the global public health response to natural occurrence, accidental release or deliberate use of biological and chemical agents or radionuclear material that affect health;

(2) to further develop and implement the core capacities as defined in Annex 1 of the International Health Regulations (2005), as applicable, and those required for participation in the International Food Safety Authorities Network, specifically for food-safety events, including the development of systems for: surveillance for foodborne disease and food contamination; risk assessment, traceability, risk management, including the Hazard Analysis and Critical Control Points system, and risk communication; food safety emergency response; product tracing and recall; and strengthened laboratory capacity;

(3) to participate fully as members of the International Food Safety Authorities Network in its activities, including supporting the timely transmission of data, information and knowledge about food-safety emergencies through the Network in a transparent manner;

(4) to enhance the integration of food-safety considerations into food aid, food security and nutrition interventions in order to reduce the occurrence of foodborne diseases and improve the health outcomes of populations in particular the vulnerable groups;

(5) to establish or improve the evidence base for food safety through systematic efforts on disease-burden estimation and surveillance, and through comprehensive risk and risk-benefit

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<sup>1</sup> And, where applicable, regional economic integration organizations.

assessment, and to provide support for international activities in these areas, in particular, WHO's initiative to estimate the global burden of foodborne diseases from all major causes (microbiological, parasitic and chemical);

(6) to contribute to the timely conduct of international risk assessments through the provision of relevant data and expertise in order to tackle more efficiently and consistently foodborne diseases and food-safety issues that threaten global public health security;

(7) to continue to develop and maintain sustainable preventive measures, including food safety-education programmes, aimed at reducing the burden of foodborne diseases through a systems approach encompassing the complete food-production chain from farm to consumption;

(8) to promote dialogue and collaboration among human health, veterinary and food-related disciplines, within and among Member States, focused on an integrated effort of foodborne risk reduction along the whole food-production chain, including consideration of zoonotic risks;

(9) to participate actively in the Codex Alimentarius Commission's standard-setting process and to adopt Codex standards whenever appropriate;

## 2. REQUESTS the Director-General:

(1) to develop the International Food Safety Authorities Network further through the implementation of WHO's global strategy for food safety; to encourage communication and technical exchange of risk assessments and best practices among members of the Network; to facilitate Member States' involvement in the Network's operation and development; and to encourage additional membership into the International Food Safety Authorities Network;

(2) to strengthen the emergency function of the International Food Safety Authorities Network as a critical component of WHO's preventive and emergency operations relative to food safety, and linkages to other relevant international organizations and networks in this area;

(3) to continue to provide global leadership in providing technical assistance and tools that meet the needs of Member States and the Secretariat for scientific estimations of foodborne risks and foodborne disease burden from all causes;

(4) to promote the inclusion of food safety into the international debate on food crises and hunger emergencies, and provide technical support to Member States and international agencies for considering food safety, nutrition and food security issues in a comprehensive, integrated manner;

(5) to monitor regularly and report to Member States on the global burden of foodborne and zoonotic diseases from the country, regional and international perspectives;

(6) to promote research, including the safety and quality of traditional foods, and investigation of the association of foodborne hazards with acute and chronic diseases, in order to support evidence-based strategies for the control and prevention of foodborne and zoonotic diseases such as the Hazard Analysis and Critical Control Points system;

(7) to provide support to Member States in building relevant capacity to improve cross-sectoral collaboration and action at international, regional and national levels along the whole food-production chain, including the assessment, management and communication of foodborne and zoonotic risks;

- (8) to develop guidance on the public health aspects arising from zoonotic diseases that originate at the human-animal interface, in particular prevention, detection and response;
- (9) to provide adequate and sustainable support for the joint expert bodies of FAO and WHO, the Codex Alimentarius Commission and the International Food Safety Authorities Network in order to advance the international development, provision, use, and sharing of scientific risk assessments and advice; to support the development of international food standards that protect the health and nutritional well-being of consumers; and to address and communicate more effectively on food safety issues at the national and international levels;
- (10) to establish with the International Food Safety Authorities Network an international initiative for the collaboration of laboratory partners in support of surveillance of foodborne disease, identification of food contamination and emergency response, including outbreak investigation and linking product to illness in order to support recall, with that initiative also including the establishment of mechanisms for data sharing;
- (11) to report to the Sixty-fifth World Health Assembly, through the Executive Board, on progress in implementing this resolution.

(Seventh plenary meeting, 20 May 2010 –  
Committee A, third report)

**WHA63.4      Financial report and audited financial statements for the period  
1 January 2008 – 31 December 2009**

The Sixty-third World Health Assembly,

Having examined the Financial report and audited financial statements for the period 1 January 2008 – 31 December 2009;<sup>1</sup>

Having noted the second report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-third World Health Assembly,<sup>2</sup>

ACCEPTS the Director-General's Financial report and audited financial statements for the period 1 January 2008 – 31 December 2009.

(Eighth plenary meeting, 21 May 2010 –  
Committee B, first report)

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<sup>1</sup> Document A63/32.

<sup>2</sup> Document A63/51 Rev.1.

**WHA63.5      Scale of assessments 2010–2011**

The Sixty-third World Health Assembly,

Having considered the report on scale of assessments 2010–2011;<sup>1</sup>

Considering that a new United Nations scale of assessments was adopted for the period 2010–2012;<sup>2</sup>

Recalling that the Health Assembly, in resolution WHA56.33, decided to accept henceforth the latest available United Nations scale of assessment for assessed contributions of Member States, taking into account differences in membership between WHO and the United Nations,

DECIDES that the scale of assessments for the year 2011 shall be as follows:

<b>Members and Associate Members</b>	<b>WHO scale for 2011 %</b>
Afghanistan	0.0040
Albania	0.0100
Algeria	0.1280
Andorra	0.0070
Angola	0.0100
Antigua and Barbuda	0.0020
Argentina	0.2870
Armenia	0.0050
Australia	1.9331
Austria	0.8511
Azerbaijan	0.0150
Bahamas	0.0180
Bahrain	0.0390
Bangladesh	0.0100
Barbados	0.0080
Belarus	0.0420
Belgium	1.0751
Belize	0.0010
Benin	0.0030
Bhutan	0.0010
Bolivia (Plurinational State of)	0.0070
Bosnia and Herzegovina	0.0140
Botswana	0.0180
Brazil	1.6111
Brunei Darussalam	0.0280
Bulgaria	0.0380
Burkina Faso	0.0030
Burundi	0.0010
Cambodia	0.0030
Cameroon	0.0110
Canada	3.2072
Cape Verde	0.0010
Central African Republic	0.0010

<sup>1</sup> Document A63/31.

<sup>2</sup> United Nations General Assembly resolution 64/248.

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<b>Members and Associate Members</b>	<b>WHO scale for 2011 %</b>
Chad	0.0020
Chile	0.2360
China	3.1892
Colombia	0.1440
Comoros	0.0010
Congo	0.0030
Cook Islands	0.0010
Costa Rica	0.0340
Côte d'Ivoire	0.0100
Croatia	0.0970
Cuba	0.0710
Cyprus	0.0460
Czech Republic	0.3490
Democratic People's Republic of Korea	0.0070
Democratic Republic of the Congo	0.0030
Denmark	0.7361
Djibouti	0.0010
Dominica	0.0010
Dominican Republic	0.0420
Ecuador	0.0400
Egypt	0.0940
El Salvador	0.0190
Equatorial Guinea	0.0080
Eritrea	0.0010
Estonia	0.0400
Ethiopia	0.0080
Fiji	0.0040
Finland	0.5660
France	6.1234
Gabon	0.0140
Gambia	0.0010
Georgia	0.0060
Germany	8.0186
Ghana	0.0060
Greece	0.6910
Grenada	0.0010
Guatemala	0.0280
Guinea	0.0020
Guinea-Bissau	0.0010
Guyana	0.0010
Haiti	0.0030
Honduras	0.0080
Hungary	0.2910
Iceland	0.0420
India	0.5340
Indonesia	0.2380
Iran (Islamic Republic of)	0.2330
Iraq	0.0200
Ireland	0.4980
Israel	0.3840
Italy	4.9994
Jamaica	0.0140

<b>Members and Associate Members</b>	<b>WHO scale for 2011 %</b>
Japan	12.5309
Jordan	0.0140
Kazakhstan	0.0760
Kenya	0.0120
Kiribati	0.0010
Kuwait	0.2630
Kyrgyzstan	0.0010
Lao People's Democratic Republic	0.0010
Latvia	0.0380
Lebanon	0.0330
Lesotho	0.0010
Liberia	0.0010
Libyan Arab Jamahiriya	0.1290
Lithuania	0.0650
Luxembourg	0.0900
Madagascar	0.0030
Malawi	0.0010
Malaysia	0.2530
Maldives	0.0010
Mali	0.0030
Malta	0.0170
Marshall Islands	0.0010
Mauritania	0.0010
Mauritius	0.0110
Mexico	2.3562
Micronesia (Federated States of)	0.0010
Monaco	0.0030
Mongolia	0.0020
Montenegro	0.0040
Morocco	0.0580
Mozambique	0.0030
Myanmar	0.0060
Namibia	0.0080
Nauru	0.0010
Nepal	0.0060
Netherlands	1.8551
New Zealand	0.2730
Nicaragua	0.0030
Niger	0.0020
Nigeria	0.0780
Niue	0.0010
Norway	0.8711
Oman	0.0860
Pakistan	0.0820
Palau	0.0010
Panama	0.0220
Papua New Guinea	0.0020
Paraguay	0.0070
Peru	0.0900
Philippines	0.0900
Poland	0.8281
Portugal	0.5110
Puerto Rico	0.0010



<b>Members and Associate Members</b>	<b>WHO scale for 2011 %</b>
Qatar	0.1350
Republic of Korea	2.2602
Republic of Moldova	0.0020
Romania	0.1770
Russian Federation	1.6021
Rwanda	0.0010
Saint Kitts and Nevis	0.0010
Saint Lucia	0.0010
Saint Vincent and the Grenadines	0.0010
Samoa	0.0010
San Marino	0.0030
Sao Tome and Principe	0.0010
Saudi Arabia	0.8301
Senegal	0.0060
Serbia	0.0370
Seychelles	0.0020
Sierra Leone	0.0010
Singapore	0.3350
Slovakia	0.1420
Slovenia	0.1030
Solomon Islands	0.0010
Somalia	0.0010
South Africa	0.3850
Spain	3.1772
Sri Lanka	0.0190
Sudan	0.0100
Suriname	0.0030
Swaziland	0.0030
Sweden	1.0641
Switzerland	1.1301
Syrian Arab Republic	0.0250
Tajikistan	0.0020
Thailand	0.2090
The former Yugoslav Republic of Macedonia	0.0070
Timor-Leste	0.0010
Togo	0.0010
Tokelau	0.0010
Tonga	0.0010
Trinidad and Tobago	0.0440
Tunisia	0.0300
Turkey	0.6170
Turkmenistan	0.0260
Tuvalu	0.0010
Uganda	0.0060
Ukraine	0.0870
United Arab Emirates	0.3910
United Kingdom of Great Britain and Northern Ireland	6.6045
United Republic of Tanzania	0.0080
United States of America	22.0000
Uruguay	0.0270
Uzbekistan	0.0100

<b>Members and Associate Members</b>	<b>WHO scale for 2011 %</b>
Vanuatu	0.0010
Venezuela (Bolivarian Republic of)	0.3140
Viet Nam	0.0330
Yemen	0.0100
Zambia	0.0040
Zimbabwe	0.0030
<b>Total</b>	<b>100.0000</b>

(Eighth plenary meeting, 21 May 2010 –  
Committee B, first report)

### **WHA63.6      Safety and security of staff and premises**

The Sixty-third World Health Assembly,

Having considered the report on safety and security of staff and premises and the Capital Master Plan: safety and security of staff, and noting the related report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-third World Health Assembly;<sup>1</sup>

Concerned about the vulnerability of the Organization with regard to staff safety and security;

Acknowledging the financial mechanism put in place by the Secretariat in order to ensure sustainable funding for security;

Recognizing the urgent requirements that have been identified and the associated financing needed for ensuring safety and security of staff and premises;

Considering the inadequate balance in the Security Fund,

1. RESOLVES to appropriate US\$ 10 million from Member States' non-assessed income to the Security Fund in order to cover the costs of urgent actions to ensure the safety and security of staff and premises;
2. REQUESTS the Director-General to report to the Executive Board at its 128th session in January 2011 on the implementation of projects funded through the Security Fund.

(Eighth plenary meeting, 21 May 2010 –  
Committee B, first report)

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<sup>1</sup> Documents A63/35 and A63/54, respectively.

**WHA63.7      The Capital Master Plan**

The Sixty-third World Health Assembly,

Having considered the report on safety and security of staff and premises and the Capital Master Plan: the Capital Master Plan<sup>1</sup> and noting the related report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-third World Health Assembly;<sup>2</sup>

Recalling the need for a strategic approach to the management of the Organization's physical infrastructure through the Capital Master Plan for the period 2010–2019;

Recognizing that much of WHO's building stock is old and in need of renovation, and no longer meets acceptable standards of safety, security and energy efficiency;

Having considered the actions taken by other organizations in the United Nations system to finance major renovations, construction and acquisitions;

Having also considered the Organization's immediate and continuing needs for renovations, construction and acquisitions, and the options for financing the Capital Master Plan;

Having further considered the merits of the options for establishing a sustainable mechanism for funding the Real Estate Fund,

1. RESOLVES to appropriate US\$ 22 million from Member States' non-assessed income to the Real Estate Fund in order to cover the costs of urgently needed renovation;
2. AUTHORIZES the Director-General:
  - (1) to allocate, at the end of each financial period, up to US\$ 10 million, as available, from the Member States' non-assessed income to the Real Estate Fund in order to finance the projects identified in the Capital Master Plan;
  - (2) to proceed with the technical studies and initiate work on the urgent projects identified in the report,<sup>1</sup> particularly those pertaining to the headquarters perimeter and construction of associated facilities;
3. REQUESTS the Director-General to report to the Executive Board at its 128th session in January 2011 on the implementation of projects funded through the Real Estate Fund.

(Eighth plenary meeting, 21 May 2010 –  
Committee B, first report)

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<sup>1</sup> Document A63/36.

<sup>2</sup> Document A63/55.

**WHA63.8 Report of the External Auditor**

The Sixty-third World Health Assembly,

Having considered the report of the External Auditor to the Health Assembly;<sup>1</sup>

Having noted the eighth report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-third World Health Assembly,<sup>2</sup>

ACCEPTS the report of the External Auditor to the Health Assembly.

(Eighth plenary meeting, 21 May 2010 –  
Committee B, first report)

**WHA63.9 Salaries of staff in ungraded posts and of the Director-General**

The Sixty-third World Health Assembly,

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

1. ESTABLISHES the salaries of Assistant Directors-General and Regional Directors at US\$ 183 022 gross per annum before staff assessment, resulting in a modified net salary of US\$ 131 964 (dependency rate) or US\$ 119 499 (single rate);
2. ESTABLISHES the salary of the Deputy Director-General at US\$ 201 351 gross per annum before staff assessment, resulting in a modified net salary of US\$ 143 878 (dependency rate) or US\$ 129 483 (single rate);
3. ESTABLISHES the salary of the Director-General at US\$ 247 523 gross per annum before staff assessment, resulting in a modified net salary of US\$ 173 890 (dependency rate) or US\$ 154 641 (single rate);
4. DECIDES that those adjustments in remuneration shall take effect from 1 January 2010.

Eighth plenary meeting, 21 May 2010 –  
Committee B, first report

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<sup>1</sup> Document A63/37.

<sup>2</sup> Document A63/56 Rev.1.

**WHA63.10 Partnerships<sup>1</sup>**

The Sixty-third World Health Assembly,

Having considered the report on partnerships;<sup>2</sup>

Recognizing the critical need for, and contribution of, collaborative work by WHO to achieve health outcomes and the diversity of such collaborations;

Noting that WHO's Constitution, the Eleventh General Programme of Work, 2006–2015 and the Medium-term strategic plan 2008–2013 describe collaboration and coordination as core functions of the Organization;

Noting further that the growth of health partnerships and other forms of collaboration have increased greatly in the past decade;

Considering the need for WHO to have a policy governing its engagement in, and hosting of, partnerships in a manner that avoids duplication of WHO's core responsibilities in partnerships' activities;

Welcoming the collaboration of WHO with stakeholders based on clear distinction of roles that creates added value, synergies and coordination among different programmes that support achievement of global and national health outcomes and reduced transaction costs,

1. ENDORSES the policy on WHO's engagement with global health partnerships and hosting arrangements;<sup>3</sup>
2. CALLS UPON Member States to take the policy into account when seeking engagement by the Director-General in partnerships, in particular with regard to hosting arrangements;
3. INVITES concerned organizations of the United Nations system, international development partners, international financial institutions, nongovernmental organizations, representatives of communities affected by diseases, and private-sector entities to enhance their collaboration with WHO, in a synergistic manner, in order to attain the strategic objectives contained in the Medium-term strategic plan 2008–2013;
4. REQUESTS the Director-General:
  - (1) to continue collaboration with concerned organizations of the United Nations system, international development partners, international financial institutions, nongovernmental organizations, representatives of communities affected by diseases, and private-sector entities in implementing the Medium-term strategic plan 2008–2013 in order to advance the global health agenda contained in the Eleventh General Programme of Work, 2006–2015;
  - (2) to create an operational framework for WHO's hosting of formal partnerships;

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<sup>1</sup> For financial and administrative implications for the Secretariat of this resolution, see document A63/44 Add.1.

<sup>2</sup> Documents A63/44 and A63/44 Corr.1.

<sup>3</sup> See Annex 1.

- (3) to apply the policy on WHO's engagement with global health partnerships and hosting arrangements, to the extent possible and in consultation with the relevant partnerships, to current hosting arrangements with a view to ensuring their compliance with the principles embodied in the policy;
- (4) to submit to the Executive Board any proposals for WHO to host formal partnerships for its review and decision;
- (5) to report on progress in implementing this resolution to the Sixty-fifth World Health Assembly through the Executive Board, and on the various actions taken by the Secretariat in relation to partnerships in implementing the policy on partnerships.

(Eighth plenary meeting, 21 May 2010 –  
Committee B, first report)

### **WHA63.11 Agreements with intergovernmental organizations<sup>1</sup>**

The Sixty-third World Health Assembly,

Having considered the report on agreements with intergovernmental organizations: collaboration between WHO and the Office International des Épidémiologies<sup>2</sup> with its proposed amendment to the Agreement between the Office International des Épidémiologies and the World Health Organization;<sup>3</sup>

Considering Article 70 of the Constitution of WHO,

APPROVES the following amendment to the Agreement between the Office International des Épidémiologies and the World Health Organization:

Article 4 is amended by the addition of the following text to be inserted as subparagraph 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."

(Eighth plenary meeting, 21 May 2010 –  
Committee B, first report)

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<sup>1</sup> See Annex 2.

<sup>2</sup> Document A63/46.

<sup>3</sup> *Basic documents*, 47th edition. Geneva, World Health Organization, 2009.

**WHA63.12 Availability, safety and quality of blood products<sup>1,2</sup>**

The Sixty-third World Health Assembly,

Having considered the report on availability, safety and quality of blood products;<sup>3</sup>

Recalling resolution WHA58.13 on blood safety: proposal to establish World Blood Donor Day and preceding related resolutions since resolution WHA28.72 on utilization and supply of human blood and blood products, which urged Member States to promote the full implementation of well-organized, nationally coordinated and sustainable blood programmes with appropriate regulatory systems and to enact effective legislation governing the operation of blood services;

Recognizing that achieving self-sufficiency, unless special circumstances preclude it, in the supply of safe blood components based on voluntary, non-remunerated blood donation, and the security of that supply are important national goals to prevent blood shortages and meet the transfusion requirements of the patient population;

Conscious that plasma-derived medicinal products for the treatment of haemophilia and immune diseases are included in the WHO Model List of Essential Medicines<sup>4</sup> and of the need to facilitate access to these products by developing countries;

Concerned by the unequal access globally to blood products, particularly plasma-derived medicinal products, leaving many patients in need of transfusion and with severe congenital and acquired disorders without adequate treatment;

Aware that a major factor limiting the global availability of plasma-derived medicinal products is an inadequate supply of plasma meeting internationally recognized standards for fractionation;

Bearing in mind that treatment using labile blood components is gradually being included in medical practice in developing countries and that thereby increased quantities of recovered plasma should become available for fractionation into plasma-derived medicinal products to meet their needs;

Concerned that in developing countries blood components separation technology and fractionation capacity are lacking, and that, because of insufficient regulatory controls and failure to implement appropriate practices in blood establishments, plasma from developing countries is often unacceptable for contract fractionation, with considerable wastage of plasma as a result;

Convinced that assuring the suitability of plasma for fractionation requires the establishment of a nationally coordinated and sustainable plasma programme within a properly organized, legally established and regulated national blood programme;

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<sup>1</sup> For financial and administrative implications for the Secretariat of this resolution, see document EB126/19 Add.1.

<sup>2</sup> The term “blood products” is defined by the Expert Committee on Biological Standardization as follows: “any therapeutic substances derived from human blood, including whole blood, labile blood components and plasma-derived medicinal products”.

<sup>3</sup> Document A63/20.

<sup>4</sup> The WHO Model List of Essential Medicines identifies individual medicines that together could provide safe and effective treatment for most communicable and noncommunicable diseases. This List includes plasma-derived medicinal products, namely immunoglobulins and coagulation factors, which are needed to prevent and treat a variety of serious conditions that occur worldwide /<http://www.who.int/medicines/publications/essentialmedicines/en/index.html>).

Recognizing that, as the capacity to collect plasma is limited and would not suffice to produce enough essential medicines to cover global needs, it is essential that all countries have local capacity to collect plasma of acceptable quality and safety from voluntary and unpaid donations in order to meet their needs;

Convinced that fractionation should be set up as close to the source as possible, and that, where national plasma fractionation capacities are lacking, there should be an option for supply of fractionation capacity in other countries, ensuring that the supply of plasma-derived medicinal products can be made available to meet local needs in the country of the plasma supplier;

Recognizing that access to information about strategies to ensure supplies of blood products sufficient to meet demand, effective mechanisms of regulatory oversight, technologies to ensure the quality and safety of blood products, and guidelines on the appropriate clinical use of blood products and the risks of transfusion have become more and more necessary;

Bearing in mind that voluntary and non-remunerated blood donations can contribute to high safety standards for blood and blood components, and being aware that the safety of blood products depends on testing of all donated blood for transfusion-transmissible infections, and correct labelling, storage and transportation of blood products;

Bearing in mind that patient blood management means that before surgery every reasonable measure should be taken to optimize the patient's own blood volume, to minimize the patient's blood loss and to harness and optimize the patient-specific physiological tolerance of anaemia following WHO's guidance for optimal clinical use (the three pillars of patient blood management);<sup>1</sup>

Recognizing that excessive and unnecessary use of transfusions and of plasma-derived medicinal products, unsafe transfusion practices, and errors (particularly at the patient's bedside) seriously compromise patient safety;

Concerned that unsafe and/or poor-quality blood products can render patients vulnerable to avoidable risk if the blood programmes are not subject to the level of control now exercised by experienced national or regional regulatory authorities;

Alarmed that patients in developing countries continue to be exposed to the risk of preventable transfusion-transmitted infections by bloodborne pathogens such as hepatitis B virus, hepatitis C virus and HIV;

Noting the increasing movement across boundaries of blood products and blood safety-related in vitro diagnostic devices, together with their rapid development and introduction into health-care systems of both developed and developing countries;

Recognizing the value of WHO International Biological Reference Preparations (International Standards) for the quality control of blood products and related in vitro diagnostic devices for detection of known and emerging bloodborne pathogens;

Convinced that traceability at all stages of the preparation of blood products, from the donor to the recipient and vice versa, is essential to identify risks, particularly the transmission of pathogens and transfusion reactions, and to monitor the efficacy of corrective measures aiming to minimize such risks;

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<sup>1</sup> *The clinical use of blood: manual*. Geneva, World Health Organization, 2002.



Convinced that good practices need to be implemented for recruiting voluntary, non-remunerated healthy blood and plasma donors from low-risk donor populations and testing of all donated blood for transfusion-transmissible pathogens, and that the whole chain of processes in the production of blood products, i.e. correct processing, labelling, storage and transportation, needs to be covered by relevant, reliable quality-assurance systems;

Recognizing that stringent regulatory control is vital in assuring the quality and safety of blood products, as well as of related in vitro diagnostic devices, and that special effort is needed to strengthen globally the technical capacity of regulatory authorities to assure the appropriate control worldwide;

Recalling previous resolutions of the Health Assembly that mention the vital need to strengthen blood establishments and ensure the quality, safety and efficacy of blood products,

1. URGES Member States:<sup>1</sup>

(1) to take all the necessary steps to establish, implement and support nationally-coordinated, efficiently-managed and sustainable blood and plasma programmes according to the availability of resources, with the aim of achieving self-sufficiency, unless special circumstances preclude it;

(2) to take all the necessary steps to update their national regulations on donor assessment and deferral, the collection, testing, processing, storage, transportation and use of blood products, and operation of regulatory authorities in order to ensure that regulatory control in the area of quality and safety of blood products across the entire transfusion chain meets internationally recognized standards;

(3) to establish quality systems, for the processing of whole blood and blood components, good manufacturing practices for the production of plasma-derived medicinal products and appropriate regulatory control, including the use of diagnostic devices to prevent transfusion-transmissible diseases with highest sensitivity and specificity;

(4) to build human resource capacity through the provision of initial and continuing training of staff to ensure quality of blood services and blood products;

(5) to enhance the quality of evaluation and regulatory actions in the area of blood products and associated medical devices, including in vitro diagnostic devices;

(6) to establish or strengthen systems for the safe and rational use of blood products and to provide training for all staff involved in clinical transfusion, to implement potential solutions in order to minimize transfusion errors and promote patient safety, to promote the availability of transfusion alternatives including, where appropriate, autologous transfusion and patient blood management;

(7) to ensure the reliability of mechanisms for reporting serious or unexpected adverse reactions to blood and plasma donation and to the receipt of blood components and plasma-derived medicinal products, including transmissions of pathogens;

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<sup>1</sup> And, where applicable, regional economic integration organizations.

2. REQUESTS the Director-General:

- (1) to guide Member States to meet internationally recognized standards in updating their legislation, national standards and regulations for effective control of the quality and safety of blood products and associated medical devices, including in vitro diagnostics;
- (2) to advise and build capacity in Member States on leadership and management of blood supply systems in order to strengthen national coordinated and sustainable blood and plasma programmes by sharing best practices about the organizational structure of blood supply systems in order to increase efficiency and minimize error;
- (3) to augment the support offered to Member States for developing and strengthening their national regulatory authorities and control laboratories so as to increase their competence in the control of blood products and associated medical devices, including in vitro diagnostic devices, and to foster the creation of regional collaborative and regulatory networks where necessary and appropriate;
- (4) to ensure sustainable development and provision of WHO International Biological Reference Preparations (International Standards) for use in the quality control and regulation of blood products and related in vitro diagnostic devices;
- (5) to improve access by developing countries to WHO International Biological Reference Preparations and to the scientific information obtained in their validation in order to assure the appropriate use of these preparations;
- (6) to develop, provide and disseminate guidance and technical support to strengthen national coordinated blood and plasma programmes and introduction of blood component separation and plasma fractionation technology, to meet local needs, and promote effective regulatory oversight of blood services and implementation of good manufacturing practices in plasma-fractionation programmes, under the responsibility of regulatory authorities;
- (7) to provide guidance, training and support to Member States on safe and rational use of blood products and to support the introduction of transfusion alternatives including, where appropriate, autologous transfusion, safe transfusion practices and patient blood management;
- (8) to encourage research into new technologies for producing safe and effective blood substitutes;
- (9) to inform regularly, at least every four years, the Health Assembly, through the Executive Board, on actions taken by Member States and other partners to implement this resolution.

(Eighth plenary meeting, 21 May 2010 –  
Committee B, second report)

**WHA63.13 Global strategy to reduce the harmful use of alcohol<sup>1</sup>**

The Sixty-third World Health Assembly,

Having considered the report on strategies to reduce the harmful use of alcohol<sup>2</sup> and the draft global strategy annexed therein;

Recalling resolutions WHA58.26 on public-health problems caused by harmful use of alcohol and WHA61.4 on strategies to reduce the harmful use of alcohol,

1. ENDORSES the global strategy to reduce the harmful use of alcohol;<sup>3</sup>
2. AFFIRMS that the global strategy to reduce the harmful use of alcohol aims to give guidance for action at all levels and to set priority areas for global action, and that it is 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;
3. URGES Member States:<sup>4</sup>
  - (1) to adopt and implement the global strategy to reduce the harmful use of alcohol as appropriate in order to complement and support public health policies in Member States to reduce the harmful use of alcohol, and to mobilize political will and financial resources for that purpose;
  - (2) to continue implementation of the resolutions WHA61.4 on the strategies to reduce the harmful use of alcohol and WHA58.26 on public-health problems caused by harmful use of alcohol;
  - (3) to ensure that implementation of the global strategy to reduce the harmful use of alcohol strengthens the national efforts to protect at-risk populations, young people and those affected by harmful drinking of others;
  - (4) to ensure that implementation of the global strategy to reduce the harmful use of alcohol is reflected in the national monitoring systems and reported regularly to WHO's information system on alcohol and health;
4. REQUESTS the Director-General:
  - (1) to give sufficiently high organizational priority, and to assure adequate financial and human resources at all levels, to the prevention and reduction of harmful use of alcohol and implementation of the global strategy to reduce the harmful use of alcohol;

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<sup>1</sup> For financial and administrative implications for the Secretariat of this resolution, see document EB126/13 Add.1.

<sup>2</sup> Document A63/13.

<sup>3</sup> See Annex 3.

<sup>4</sup> And, where applicable, regional economic integration organizations.

(2) to collaborate with and provide support to Member States, as appropriate, in implementing the global strategy to reduce the harmful use of alcohol and strengthening national responses to public health problems caused by the harmful use of alcohol;

(3) to monitor progress in implementing the global strategy to reduce the harmful use of alcohol and to report progress, through the Executive Board, to the Sixty-sixth World Health Assembly.

(Eighth plenary meeting, 21 May 2010 –  
Committee A, fourth report)

### **WHA63.14 Marketing of food and non-alcoholic beverages to children<sup>1</sup>**

The Sixty-third World Health Assembly,

Having considered the report on prevention and control of noncommunicable diseases: implementation of the global strategy and its annexed set of recommendations on the marketing of foods and non-alcoholic beverages to children;<sup>2</sup>

Recalling resolutions WHA53.17 on the prevention and control of noncommunicable diseases and WHA60.23 on the prevention and control of noncommunicable diseases: implementation of the global strategy;

Reaffirming its commitment to acting on two of the main risk factors for noncommunicable diseases, namely, unhealthy diet and physical inactivity, through the implementation of the Global strategy on diet, physical activity and health, endorsed by the Health Assembly in 2004 (resolution WHA57.17), and the action plan for the global strategy for the prevention and control of noncommunicable diseases,<sup>3</sup> endorsed by the Health Assembly in 2008 (resolution WHA61.14);

Deeply concerned about the high and increasing prevalence of noncommunicable diseases in low- and middle-income countries which, together with the communicable diseases still affecting the poor, contribute to a double burden of disease which has serious implications for poverty reduction and economic development and widens health gaps between and within countries;

Deeply concerned that in 2010 it is estimated that more than 42 million children under the age of five years will be overweight or obese, of whom nearly 35 million are living in developing countries, and also concerned that in most parts of the world the prevalence of childhood obesity is increasing rapidly;

Recognizing that unhealthy diet is one of the main risk factors for noncommunicable diseases and that the risks presented by unhealthy diets start in childhood and build up throughout life;

Recognizing that unhealthy diets are associated with overweight and obesity and that children should maintain a healthy weight and consume foods that are low in saturated fat, *trans*-fatty acids, free sugars, or salt in order to reduce future risk of noncommunicable diseases;

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<sup>1</sup> For financial and administrative implications for the Secretariat of this resolution, see Annex 9.

<sup>2</sup> Document A63/12.

<sup>3</sup> Document A61/2008/REC/1, Annex 3.

Cognizant of the research that shows that food advertising to children is extensive and other forms of marketing of food to children are widespread across the world;

Recognizing that a significant amount of this marketing is for foods with a high content of fat, sugar or salt and that television advertising influences children's food preferences, purchase requests and consumption patterns;

Recognizing the steps taken so far by segments of the private sector to reduce the marketing of foods and non-alcoholic beverages to children, while noting the importance of independent and transparent monitoring of commitments made by the private sector at national and global levels;

Recognizing that some Member States have already introduced legislation and national policies on the marketing of foods and non-alcoholic beverages to children,

1. ENDORSES the set of recommendations on the marketing of foods and non-alcoholic beverages to children;<sup>1</sup>
2. URGES Member States:
  - (1) to take necessary measures to implement the recommendations on the marketing of foods and non-alcoholic beverages to children, while taking into account existing legislation and policies, as appropriate;
  - (2) to identify the most suitable policy approach given national circumstances and develop new and/or strengthen existing policies that aim to reduce the impact on children of marketing of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt;
  - 3) to establish a system for monitoring and evaluating the implementation of the recommendations on the marketing of foods and non-alcoholic beverages to children;
  - (4) to take active steps to establish intergovernmental collaboration in order to reduce the impact of cross-border marketing;
  - (5) to cooperate with civil society and with public and private stakeholders in implementing the set of recommendations on the marketing of foods and non-alcoholic beverages to children in order to reduce the impact of that marketing, while ensuring avoidance of potential conflicts of interest;
3. REQUESTS the Director-General:
  - (1) to provide technical support to Member States, on request, in implementing the set of recommendations on the marketing of foods and non-alcoholic beverages to children and in monitoring and evaluating their implementation;
  - (2) to support existing regional networks, and where appropriate to facilitate the establishment of new ones, in order to strengthen international cooperation to reduce the impact on children of marketing of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt;

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<sup>1</sup> See Annex 4.

- (3) to cooperate with civil society and with public and private stakeholders in implementing the set of recommendations to reduce the impact of marketing of foods and non-alcoholic beverages to children, while ensuring avoidance of potential conflicts of interest;
- (4) to strengthen international cooperation with other international intergovernmental organizations and bodies in promoting the implementation, by Member States, of the recommendations on marketing of foods and non-alcoholic beverages to children;
- (5) to use existing methodologies for evaluating the action plan for the global strategy for the prevention and control of noncommunicable diseases to monitor policies on marketing of foods and non-alcoholic beverages to children;
- (6) to report on implementation of the set of recommendations on the marketing of foods and non-alcoholic beverages to children as part of the report on progress in implementing the global strategy on prevention and control of noncommunicable diseases and the action plan for the global strategy for the prevention and control of noncommunicable diseases to the Sixty-fifth World Health Assembly through the Executive Board.

Eighth plenary meeting, 21 May 2010 –  
Committee A, fourth report)

### **WHA63.15      Monitoring of the achievement of the health-related Millennium Development Goals<sup>1</sup>**

The Sixty-third World Health Assembly,

Having considered the report on monitoring of the achievement of the health-related Millennium Development Goals;<sup>2</sup>

Recalling resolution WHA61.18 on monitoring of the achievement of the health-related Millennium Development Goals;

Recalling the outcomes of the major United Nations conferences and summits in the economic, social and related fields, especially those related to global health, in particular the 2005 World Summit Outcome and the commitments made by the international community to attain the Millennium Development Goals and the new commitments made during the United Nations High-level Event on the Millennium Development Goals (New York, 25 September 2008);

Stressing the importance of achieving the health-related Millennium Development Goals, especially with the objective of ensuring socioeconomic development;

Concerned by the fact that achievement of the Millennium Development Goals varies from country to country and from goal to goal;

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<sup>1</sup> For financial and administrative implications for the Secretariat of this resolution, see document EB126/2010/REC/1, Annex 7.

<sup>2</sup> Document A63/7.

Welcoming the Ministerial Declaration adopted at the annual ministerial review held by the Economic and Social Council in 2009 on implementing the internationally agreed goals and commitments in regard to global public health;

Recalling United Nations General Assembly resolution 64/108 (10 December 2009) on global health and foreign policy;

Recognizing that the Millennium Development Goals are interlinked, and reiterating the Health Assembly's commitment to continued reinvigoration and strengthening of the global partnership for development, as a vital element for achieving these Goals, in particular those related to health, inter alia, through capacity building, transfer of technology, sharing of best practices and lessons learnt, South-South cooperation, and predictability of resources;

Recalling the Monterrey Consensus of March 2002 to "urge developed countries that have not done so, to make concrete efforts towards the target of 0.7% of the gross national product (GNP) as ODA" and "encourage developing countries to build on progress achieved in ensuring that ODA is used effectively to help achieve development goals and targets";

Reaffirming the commitments by many developed countries to achieve the target of 0.7% of gross national income on official development assistance by 2015 and to reach 0.56% of gross national income for official development assistance by 2010, as well as the target of 0.15% to 0.20% for least developed countries;

Welcoming increasing efforts to improve the quality of official development assistance and to augment its development impact, such as the Development Cooperation Forum of the Economic and Social Council, the principles contained in the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, and the experience of the International Health Partnership and others, in order to strengthen national ownership, alignment, harmonization and managing for results;

Noting the work of the Leading Group on Innovative Financing for Development and of the High-level Task Force on Innovative International Financing for Health Systems, the additional pledges made by several countries to increase financing for health, and the announcements made by several countries at the United Nations General Assembly High-level Meeting on Health (New York, 23 September 2009) to achieve universal access to affordable basic health care, including provision of free services for women and children at the point of use where countries choose, and financial mechanisms toward social health protection;

Welcoming the important initiative of the United Nations Secretary-General and of the work on the Joint Action Plan to improve health of women and children and his invitation to all Member States to engage;

Expressing concern at the relatively slow progress in attaining the Millennium Development Goals, particularly in sub-Saharan Africa;

Expressing deep concern over the weak institutional capacity in health-information systems, the inadequate coverage and poor quality of civil registrations in developing countries which hamper monitoring progress of Millennium Development Goals;

Expressing deep concern that maternal, newborn and child health and universal access to reproductive health services remain constrained by health inequities, and at the slow progress in achieving Millennium Development Goals 4 and 5 on improving child and maternal health;

Welcoming the contribution of all relevant partners and progress achieved towards the goal of universal access to prevention, treatment, care and support related to HIV/AIDS;

Reaffirming WHO's leading role as the primary United Nations specialized agency for health, including its roles and functions with regard to health policy in accordance with its mandate;

Welcoming WHO's report on women and health<sup>1</sup> as important in advancing women's rights and gender equality, underlining the need to address women's health through comprehensive strategies targeting root causes of discrimination, and stressing the importance of strengthening health systems to better respond to women's health needs in terms of access and comprehensiveness;

Recognizing that health systems based on the principles of tackling health inequalities through universal access, putting people at the centre of care, integrating health into broader public policy, and providing inclusive leadership for health are essential to achieving sustainable improvements in health;

Recognizing also the growing burden of noncommunicable diseases worldwide, and recalling the importance of preventing infectious diseases that still represent a heavy burden, particularly in developing countries, the adverse impacts of the food, environmental, economic and financial crises on populations, in particular on the poorest and the most vulnerable ones, which may increase the level of malnutrition and reverse the achievement of Millennium Development Goal 1 (Eradicate extreme hunger and poverty) and the health-related Goals and the progress made in the past two decades,

1. URGES Member States:

(1) to strengthen health systems so that they deliver equitable health outcomes as a basis of a comprehensive approach towards achieving Millennium Development Goals 4, 5 and 6, underlining the need to build sustainable national health systems and strengthen national capacities through attention to, inter alia, service delivery, health systems financing, health workforce, health information systems, procurement and distribution of medicines, vaccines and technologies, sexual and reproductive health care and political will in leadership and governance;

(2) to review policies, including those on recruitment, training and retention, that exacerbate the problem of the lack of health workers, and their imbalanced distribution, within countries and throughout the world, in particular the shortage in sub-Saharan Africa, which undermines the health systems of developing countries;

(3) to reaffirm the values and principles of primary health care, including equity, solidarity, social justice, universal access to services, multisectoral action, transparency, accountability, decentralization and community participation and empowerment, as the basis for strengthening health systems, through support for health and development; taking into account leadership, public policy, universal coverage and service-delivery reforms necessary for strengthening primary health care;

(4) to take into account health equity in all national policies that address social determinants of health, and to consider developing and strengthening universal comprehensive social protection policies, including health promotion, infectious and noncommunicable disease prevention and health care, and promoting availability of and access to goods and services essential to health and well-being;

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<sup>1</sup> *Women and health: today's evidence tomorrow's agenda*. Geneva, World Health Organization, 2009.



(5) to further commit themselves to increased investment in financial and human resources and to strengthening the national health-information systems in order to generate accurate, reliable and timely evidence on achievement of the Millennium Development Goals;

(6) to renew their commitment to prevent and eliminate maternal, newborn and child mortality and morbidity: through an effective continuum of care, strengthening health systems, and comprehensive and integrated strategies and programmes to address root causes of gender inequalities and lack of access to adequate care and reproductive health, including family planning and sexual health; by promoting respect for women's rights; and by scaling up efforts to achieve integrated management of newborn and child health care, including actions to address the main causes of child mortality, in particular through interventions that increase rates of exclusive and sustained breastfeeding;

(7) to expand significantly efforts towards meeting the goal of universal access to HIV prevention, treatment, care and support by 2010 and the goal to halt and reverse the spread of HIV/AIDS by 2015;

(8) to maximize synergies between the HIV/AIDS response and strengthening of health systems and social support;

(9) to enhance policies to address the challenges of malaria including monitoring of drug resistance in artemisinin-based combination therapy;

(10) to sustain and strengthen the gains made in combating tuberculosis, and to develop innovative strategies for tuberculosis prevention, detection and treatment, including means of dealing with new threats such as coinfection with HIV, multidrug-resistant tuberculosis or extensively drug-resistant tuberculosis;

(11) to sustain commitments to support the eradication of poliomyelitis and the efforts to eliminate measles;

(12) to include best practices for strengthening health services in bilateral and multilateral initiatives addressed to the achievement of the Millennium Development Goals, in particular in South-South cooperation initiatives;

(13) to support developing countries in their national endeavours to achieve the Millennium Development Goals, in particular the health-related Millennium Development Goals, inter alia, through capacity building, transfer of technology, sharing of lessons learnt and best practices, South-South cooperation, and predictability of resources;

(14) to fulfil their commitments regarding official development assistance by 2015;

(15) to fulfil and sustain the political and financial commitment of developing country governments in mobilizing adequate budget allocation to health sectors;

2. INVITES concerned organizations of the United Nations system, international financial institutions, and calls upon international development partners and agencies, nongovernmental organizations and private sector entities to continue their support and consider further support to countries, particularly in sub-Saharan Africa, for the development and implementation of health policies and national health development plans, consistent with internationally agreed health goals, including the Millennium Development Goals.

3. REQUESTS the Director-General:

- (1) to continue to play a leading role in the monitoring of the achievement of the health-related Millennium Development Goals, including progress towards achieving universal coverage of services essential to these Goals;
- (2) within the framework of WHO's Medium-term strategic plan 2008–2013, to continue to cooperate closely with all other United Nations and international organizations involved in the process of achieving the Millennium Development Goals, maintaining a strong focus on efficient use of resources based on the respective mandates and core competencies of each, avoiding duplication of efforts and fragmentation of aid, and promoting the coordination of work among international agencies;
- (3) to provide support to Member States in their efforts to strengthen their health systems, address the problem of the lack of health workers, reaffirm the values and principles of primary health care, address the social determinants of health, and strengthen their public policies aimed at fostering full access to health and social protection, including improved access to quality medicines required to support health care for, inter alia, the most vulnerable sectors of society;
- (4) to foster alignment and coordination of global interventions for health system strengthening, basing them on the primary health care approach, in collaboration with Member States, relevant international organizations, international health initiatives, and other stakeholders in order to increase synergies between international and national priorities;
- (5) to articulate and present to the Health Assembly, as part of its action plan for the renewal of primary health care, the actions that the Secretariat envisages will strengthen its support for the achievement of Millennium Development Goals 4, 5 and 6;
- (6) to work with all relevant partners in order to achieve high immunization coverage rates with affordable vaccines of assured quality;
- (7) to lead the work with all relevant partners to help to ensure that action on the health-related Millennium Development Goals is one of the main themes of the United Nations Millennium Development Goals High-level Plenary Meeting (New York, 20–22 September 2010);
- (8) to continue to collect and compile scientific evidence needed for achieving health-related Millennium Development Goals and to disseminate it to all Member States;
- (9) to continue to submit annually a report on the status of progress made, including on main obstacles and ways to overcome them, in achievement of the health-related Millennium Development Goals, through the Executive Board, to the Health Assembly;
- (10) to assist Member States in the development of reliable health-information systems to provide quality data for monitoring and evaluation of the Millennium Development Goals.

(Eighth plenary meeting, 21 May 2010 –  
Committee A, fourth report)

**WHA63.16 WHO Global Code of Practice on the International Recruitment of Health Personnel<sup>1</sup>**

The Sixty-third World Health Assembly,

Having considered the revised draft global code of practice on the international recruitment of health personnel, annexed to the report by the Secretariat on the international recruitment of health personnel: draft global code of practice,<sup>2</sup>

1. ADOPTS, in accordance with Article 23 of the Constitution, the WHO Global Code of Practice on the International Recruitment of Health Personnel;<sup>3</sup>
2. DECIDES that the first review of the relevance and effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel shall be made by the Sixty-eighth World Health Assembly;
3. REQUESTS the Director-General:
  - (1) to give all possible support to Member States, as and when requested, for the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel;
  - (2) to cooperate with all stakeholders concerned with the implementation and monitoring of the WHO Global Code of Practice on the International Recruitment of Health Personnel;
  - (3) to rapidly develop, in consultation with Member States, guidelines for minimum data sets, information exchange and reporting on the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel;
  - (4) based upon periodic reporting, to make proposals, if necessary, for the revision of the text of the WHO Global Code of Practice on the International Recruitment of Health Personnel in line with the first review, and for measures needed for its effective application.

(Eighth plenary meeting, 21 May 2010 –  
Committee A, fourth report)

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<sup>1</sup> For financial and administrative implications for the Secretariat of this resolution, see Annex 9.

<sup>2</sup> Document A63/8.

<sup>3</sup> See Annex 5.

**WHA63.17 Birth defects<sup>1</sup>**

The Sixty-third World Health Assembly,

Having considered the report on birth defects;<sup>2</sup>

Concerned by the high number of stillbirths and neonatal deaths occurring worldwide and by the large contribution of neonatal mortality to under-five mortality;

Recognizing the importance of birth defects as a cause of stillbirths and neonatal mortality;

Mindful that effective interventions to prevent birth defects including provision of appropriate community genetic services within primary health care are available that can be integrated into maternal, reproductive and child health services as well as interventions to limit exposure to risk factors for birth defects;

Concerned by the inadequate coverage of maternal, newborn and child health interventions and the barriers to access to health services that still exist in countries with the highest burden of maternal, newborn and child deaths;

Aware that the attainment of Millennium Development Goal 4 (Reduce child mortality) will require accelerated progress in reducing neonatal mortality including prevention and management of birth defects;

Recognizing that the lack or inadequacy of vital registration systems in developing countries, and inaccurate records of the causes of death, are major barriers to estimating the size of public health problems attributable to birth defects;

Recalling resolution WHA58.31, in which the Health Assembly, calling for universal coverage of maternal, newborn and child health interventions, urged Member States to commit resources and to accelerate national action to build a seamless continuum of care for reproductive, maternal, newborn and child health; and resolution WHA57.13 in which it was recognized that genomics has a significant contribution to make in the area of public health;

Recognizing that the prevalence of birth defects varies between communities, and that insufficient epidemiological data may hamper effective and equitable management;

Recognizing the diversity of causes and determinants of congenital disorders, including preventable factors such as infections or nutritional factors, vaccine-preventable diseases, consumption of alcohol, tobacco and drugs, and exposure to chemical substances, notably pesticides;

Deeply concerned that birth defects are still not recognized as priorities in public health;

Concerned by the limited resources dedicated to prevention and management of birth defects before and after birth in particular in middle- and low-income countries,

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<sup>1</sup> For financial and administrative implications for the Secretariat of this resolution, see document EB126/2010/REC/1, Annex 7.

<sup>2</sup> Document A63/10.

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1. URGES Member States:

(1) to raise awareness among all relevant stakeholders, including government officials, health professionals, civil society and the public, about the importance of birth defects as a cause of child morbidity and mortality;

(2) to set priorities, commit resources, and develop plans and activities for integrating effective interventions<sup>1</sup> that include comprehensive guidance, information and awareness raising to prevent birth defects, and care for children with birth defects into existing maternal, reproductive and child health services and social welfare for all individuals and effective interventions to prevent tobacco and alcohol use during pregnancy;

(3) to promote the application of internationally recognized standards regulating the use of chemical substances in the air, water and soil;

(4) to increase coverage of effective prevention measures including vaccination against rubella, folic acid supplementation, programmes addressing tobacco and alcohol use among pregnant women and women who are trying to conceive, health education programmes that include ethical, legal and social issues associated with birth defects for the general population and high-risk groups, and by fostering the development of parent-patient organizations and establishing appropriate community genetic services;

(5) to develop and strengthen registration and surveillance systems for birth defects within the framework of national health information systems in order to have accurate information available for taking decisions on prevention and control of these birth defects and to continue providing care and support to individuals affected by birth defects;

(6) to develop expertise and to build capacity on the prevention of birth defects and care of children with birth defects;

(7) to strengthen research and studies on etiology, diagnosis and prevention of major birth defects and to promote international cooperation in combating them;

(8) to raise awareness among all relevant stakeholders, including government officials, health professionals, civil society and the public, about the importance of newborn screening programmes and their role in identifying infants born with congenital birth defects;

(9) to take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children, give priority to the child's well-being and support, and facilitate families in their child-care and child-raising efforts;

(10) to support families who have children with birth defects and associated disabilities, and ensure that appropriate habilitation and support is provided to children with disabilities;

2. REQUESTS the Director-General:

(1) to promote the collection of data on the global burden of mortality and morbidity due to birth defects, and to consider broadening the groups of congenital abnormalities included in the

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<sup>1</sup> See Annex 6.

classification when the International Statistical Classification of Diseases and Related Health Problems (Tenth Revision) is revised;

(2) to continue to collaborate with the International Clearinghouse for Birth Defects Surveillance and Research in order to improve collection of data on the global burden of mortality and morbidity due to birth defects;

(3) to support Member States in developing national plans for implementation of effective interventions to prevent and manage birth defects<sup>1</sup> within their national maternal, newborn and child health plan; in strengthening health systems and primary care, including improved coverage of vaccination against diseases such as measles and rubella, addressing tobacco and alcohol use among pregnant women and women trying to conceive, and food fortification strategies, in order to prevent birth defects; and in promoting equitable access to such services;

(4) to provide support to Member States in developing ethical and legal guidelines in relation to birth defects;

(5) to support Member States in the provision of appropriate community genetic services within the primary health-care system;

(6) to promote technical cooperation among Member States, nongovernmental organizations and other relevant bodies on prevention of birth defects;

(7) to support and facilitate research efforts on prevention and management of birth defects in order to improve the quality of life of those affected by such disorders;

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

(Eighth plenary meeting, 21 May 2010 –  
Committee A, fifth report)

## **WHA63.18      Viral hepatitis<sup>2</sup>**

The Sixty-third World Health Assembly,

Having considered the report on viral hepatitis;<sup>3</sup>

Taking into account the fact that some 2000 million people have been infected by hepatitis B virus and that about 350 million people live with a chronic form of the disease;

Considering that hepatitis C is still not preventable by vaccination and around 80% of hepatitis C virus infections become a chronic infection;

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<sup>1</sup> See Annex 6.

<sup>2</sup> For financial and administrative implications for the Secretariat of this resolution, see document EB126/2010/REC/1, Annex 7.

<sup>3</sup> Document A63/15.

Considering the seriousness of viral hepatitis as a global public health problem and the need for advocacy to governments, all parties and populations for action on health promotion, disease prevention, diagnosis and treatment;

Expressing concern at the lack of progress in the prevention and control of viral hepatitis in developing countries, in particular in sub-Saharan Africa, due to the lack of access to affordable, appropriate treatment and care as well as an integrated approach to the prevention and control measures of the disease;

Considering the need for a global approach to all forms of viral hepatitis – with a special focus on viral hepatitis B and C, which have the higher rates of morbidity;

Recalling that one route of transmission of hepatitis B and C viruses is parenteral and that the Health Assembly in resolution WHA28.72 on utilization and supply of human blood and blood products recommended the development of national public services for blood donation and in resolution WHA58.13 agreed to the establishment of an annual World Blood Donor Day, and that in both resolutions the Health Assembly recognized the need for safe blood to be available to blood recipients;

Reaffirming resolution WHA45.17 on immunization and vaccine quality which urged Member States to include hepatitis B vaccines in national immunization programmes;

Considering the need to reduce liver cancer mortality rates and that viral hepatitis are responsible for 78% of cases of primary liver cancer;

Considering the collaborative linkages between prevention and control measures for viral hepatitis and those for infectious diseases like HIV and other related sexually transmitted and bloodborne infections;

Recognizing the need to reduce incidence to prevent and control viral hepatitis, to increase access to correct diagnosis and to provide appropriate treatment programmes in all regions;

Further recognizing the need for universal coverage for safe injection practices as promoted through the WHO Safe Injection Global Network,

1. RESOLVES that 28 July or such other day or days as individual Member States decide shall be designated as World Hepatitis Day in order to provide an opportunity for education and greater understanding of viral hepatitis as a global public health problem, and to stimulate the strengthening of preventive and control measures of this disease in Member States;
2. URGES Member States:
  - (1) to implement and/or improve epidemiological surveillance systems and to strengthen laboratory capacity, where necessary, in order to generate reliable information for guiding prevention and control measures;
  - (2) to support or enable an integrated and cost-effective approach to the prevention, control and management of viral hepatitis considering the linkages with associated coinfection such as HIV through multisectoral collaboration among health and educational institutions, nongovernmental organizations and civil society, including measures that strengthen safety and quality and the regulation of blood products;

(3) to incorporate in their specific contexts the policies, strategies and tools recommended by WHO in order to define and implement preventive actions, diagnostic measures and the provision of assistance to the population affected by viral hepatitis including migrant and vulnerable populations;

(4) to strengthen national health systems in order to address prevention and control of viral hepatitis effectively through the provision of health promotion and national surveillance, including tools for prevention, diagnosis and treatment of viral hepatitis, vaccination, information, communication and injection safety;

(5) to provide vaccination strategies, infection-control measures, and means for injection safety for health-care workers;

(6) to use national and international resources, either human or financial, to provide technical support to strengthen health systems in order to provide local populations adequately with the most cost-effective and affordable interventions that suit the needs of local epidemiological situations;

(7) to consider, as necessary, national legislative mechanisms for the use of the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights in order to promote access to specific pharmaceutical products;<sup>1</sup>

(8) to consider, whenever necessary, using existing administrative and legal means in order to promote access to preventive, diagnostic and treatment technologies against viral hepatitis;

(9) to develop and implement monitoring and evaluation tools in order to assess progress towards reducing the burden from viral hepatitis and to guide evidence-based strategy for policy decisions related to preventive, diagnostic and treatment activities;

(10) to promote the observance of 28 July each year, or on such other day or days as individual Member States may decide, as World Hepatitis Day;

(11) to promote total injection safety at all levels of national health-care systems;

3. REQUESTS the Director-General:

(1) to establish in collaboration with Member States the necessary guidelines, strategies, time-bound goals and tools for the surveillance, prevention and control of viral hepatitis;

(2) to provide the necessary support to the development of scientific research related to the prevention, diagnosis and treatment of viral hepatitis;

(3) to improve the assessment of global and regional economic impact and estimate the burden of viral hepatitis;

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<sup>1</sup> The WTO General Council in its Decision of 30 August 2003 (i.e. on Implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health) decided that “‘pharmaceutical product’ means any patented product, or product manufactured through a patented process, of the pharmaceutical sector needed to address the public health problems as recognized in paragraph 1 of the Declaration. It is understood that active ingredients necessary for its manufacture and diagnostic kits needed for its use would be included.”



- (4) to support, as appropriate, resource-constrained Member States in conducting events to mark World Hepatitis Day;
- (5) to invite international organizations, financial institutions and other partners to give support to, and assign resources for, the strengthening of surveillance systems, prevention and control programmes, diagnostic and laboratory capacity, and management of viral hepatitis to developing countries in an equitable, most efficient, and suitable manner;
- (6) to strengthen the WHO Safe Injection Global Network;
- (7) to collaborate with other organizations in the United Nations system, partners, international organizations and other relevant stakeholders in enhancing access to affordable treatments in developing countries;
- (8) to report to the Sixty-fifth World Health Assembly, through the Executive Board, on the implementation of this resolution.

(Eighth plenary meeting, 21 May 2010 –  
Committee A, fifth report)

### **WHA63.19 WHO HIV/AIDS strategy for 2011–2015<sup>1</sup>**

The Sixty-third World Health Assembly,

Considering that the HIV epidemic still constitutes one of the foremost challenges to health and development, both in countries with generalized epidemics and in regions with concentrated epidemics affecting those people most at risk, such as men who have sex with men, sex workers and injecting drug users;

Noting that globally HIV is the major cause of mortality among women of reproductive age and was responsible for the death of 280 000 children in 2008, thereby undermining efforts to achieve Millennium Development Goals 4 and 5;

Recognizing that the significant gains made in prevention and treatment of HIV/AIDS need to be sustained and expanded for Millennium Development Goal 6 to be achieved, including the urgent need to strengthen targeted prevention measures and achieve universal access to antiretroviral treatment, within a framework of respect for human rights, gender equality, and the reduction of stigmatization and discrimination;

Further recognizing the need to strengthen the linkages between prevention and treatment of HIV/AIDS and maternal and child health in order to achieve Millennium Development Goals 4 and 5;

Recalling that WHO's work on HIV/AIDS has been guided by a series of strategies endorsed by several World Health Assemblies, including resolutions WHA53.14, WHA56.30, WHA59.12 and WHA59.19;

Considering that WHO's "3 by 5" initiative, launched in 2003, which focused on expanding access to antiretroviral treatment, was developed in the context of the Global health sector strategy

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<sup>1</sup> For financial and administrative implications for the Secretariat of this resolution, see Annex 9.

for HIV/AIDS (2003–2007), endorsed by the Fifty-sixth World Health Assembly (in resolution WHA56.30);

Recalling that in 2006 the United Nations General Assembly in its Political Declaration on HIV/AIDS adopted the target of universal access to HIV prevention, treatment and care by 2010,<sup>1</sup> and WHO developed the universal access plan 2006–2010, noted by the Fifty-ninth World Health Assembly, which has guided WHO's work since then; keeping in mind the outcomes of the Second Independent Evaluation of UNAIDS (2009);

Recognizing the need for countries to sustain commitment to addressing the HIV/AIDS epidemic at all levels, including the highest political level, and to be supported in their efforts to expand the scope, improve the effectiveness and ensure the sustainability of their HIV responses so as to enable them to achieve the Millennium Development Goals;

Noting that a sustainable HIV response requires its integration into comprehensive health systems, including those for maternal, neonatal and child health, sexual and reproductive health, tuberculosis prevention and control, harm reduction for drug users,<sup>2</sup> and primary health care, particularly noting that sustaining these efforts is challenging in light of the global financial crisis;

Recognizing that antiretroviral treatment programmes take a major share of total national AIDS spending in most countries, which warrants paying attention immediately to reviewing and improving the performance of those programmes through early recruitment, ensuring highest adherence to medications, limiting drug resistance, minimizing risk behaviours, and enhancing the level of national spending on HIV prevention and control measures;

Expressing deep concern that the financing of HIV programmes in most developing countries relies on external financial resources contributed by donors and global health initiatives, with space for improvement in their adherence to aid effectiveness commitments, and that limited national financial resources hamper the financial sustainability of HIV programmes,

1. URGES Member States:

- (1) to reaffirm their commitment to achieving the internationally agreed development goals and objectives, including the Millennium Development Goals, in particular the goal to halt and begin to reverse the spread of HIV/AIDS, malaria and other major diseases, and to the agreements dealing with HIV/AIDS reached at all major United Nations conferences and summits, including the 2005 World Summit and its statement on treatment, and the goal of achieving universal access to reproductive health by 2015, as set out at the 2005 World Summit;
- (2) to increase governments' commitment to HIV/AIDS programmes including increased efforts on prevention and to take steps to accelerate donor harmonization and adherence to aid effectiveness commitments;
- (3) to incorporate, based on national contexts, the policies, strategies, programmes and interventions and tools recommended by WHO in order to implement effective HIV prevention measures, early diagnosis, treatment and care; and take further steps towards minimizing social stigmatization and discrimination which hamper access to prevention, treatment and care;

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<sup>1</sup> United Nations General Assembly resolution 60/262.

<sup>2</sup> Aligned with the *WHO/UNODC/UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*. Geneva, WHO, 2009.

(4) to consider, whenever necessary, using existing administrative and legal mechanisms in order to promote access to affordable and cost-effective prevention, treatment and care;

(5) to integrate HIV/AIDS services into comprehensive strategies in health and other relevant sectors, including those for maternal, neonatal and child health, sexual and reproductive health, tuberculosis, harm reduction<sup>1</sup> and primary health care, in order to ensure sustainability and maximize efficiencies and effectiveness;

(6) to monitor closely and evaluate HIV/AIDS programmes by ensuring the completeness, accuracy and reliability of the data and use that information to improve programme efficiency;

2. REQUESTS the Director-General:

(1) to take the lead in convening broad consultative processes to develop a WHO HIV/AIDS strategy for 2011–2015 which will guide the Secretariat's support to Member States in line with UNAIDS guiding policies, including the Outcome Framework<sup>1</sup> and aligned with broader strategic frameworks, including the Millennium Development Goals and primary health care, and which builds on the five strategic directions of the Universal Access Plan, and takes into consideration the changing international public health architecture, and reflect the Paris Declaration on Aid Effectiveness;

(2) to encourage and promote the translation of research results into efficient public health policies for HIV/AIDS;

(3) to submit to the Sixty-fourth World Health Assembly through the Executive Board a WHO HIV/AIDS strategy for 2011–2015 for its consideration and possible endorsement.

(Eighth plenary meeting, 21 May 2010 –  
Committee A, fifth report)

## **WHA63.20 Chagas disease: control and elimination<sup>2</sup>**

The Sixty-third World Health Assembly,

Having considered the report on Chagas disease: control and elimination,<sup>3</sup>

Recognizing that all transmission routes (namely by vectors, transfusion, organ transplantation, and by vertical and oral routes) have to be tackled, and that, in particular, domestic vectorial transmission in Latin America has to be eliminated, with the understanding that elimination means stable interruption of domestic transmission;

Expressing its satisfaction at the considerable progress achieved by countries towards the goal of eliminating Chagas disease, as recommended in resolution WHA51.14;

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<sup>1</sup> *Joint action for results: UNAIDS Outcome Framework 2009–2011*. Geneva, UNAIDS, 2010 (document UNAIDS/09.13E).

<sup>2</sup> For financial and administrative implications for the Secretariat of this resolution, see document EB124/2009/REC/1, Annex 7.

<sup>3</sup> Document A63/17.

Underlining that 2009 marked the centenary of the description of this disease by Dr Carlos Chagas;

Recognizing the success achieved through the intergovernmental initiatives in Latin America, and acknowledging the progress made through vector-control strategies;

Recognizing the increasing number of cases of Chagas disease in countries where the disease is not endemic;

Taking into account the need for harmonization of diagnostic and treatment procedures;

Recognizing the need for the provision of appropriate medical care for people affected by Chagas disease;

Underlining the need for more effective, safe and adequate medicines, including paediatric formulations, and for better coverage and distribution of those currently available;

Recalling resolution CD49.R19 adopted by the 49th Directing Council of PAHO in 2009, which urges Member States to commit themselves to the elimination or the reduction of neglected diseases and other related poverty diseases, including Chagas disease, with the aim that disease no longer represents a public health problem;

Acknowledging the significant collaboration and support among Member States and the support of other partners and appreciating their continuous assistance,

1. URGES Member States:

- (1) to reinforce efforts to strengthen and consolidate national control programmes especially in areas where Chagas disease has re-emerged, in disease-endemic and non-endemic countries and to establish them where there are none;
- (2) to establish mechanisms to ensure broad coverage of adequate control measures, including the promotion of decent and healthy living conditions, prevention, and the integration of specific actions within health services based on primary health care, together with strengthening community participation;
- (3) to harmonize systems and strengthen capacities for surveillance, data collection and analysis and dissemination of information;
- (4) to integrate the care of patients with acute and chronic clinical forms of Chagas disease into primary health services;
- (5) to reinforce the provision of existing treatments in countries where Chagas disease is endemic with the aim of making access universal;
- (6) to promote and encourage operational research on control of Chagas disease in order:
  - (a) to interrupt transmission by domestic insect vectors through their control and elimination;
  - (b) to promote the development of medicines that are more suitable, safe and affordable;

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- (c) to promote the development of a valid and accessible test of cure;
  - (d) to reduce the risk of late complications of the infection;
  - (e) to establish systems of early detection, in particular for the detection of new infections, congenital infections in newborns and the reactivation of the disease in immunocompromised patients;
  - (f) to optimize blood transfusion safety and screening procedures in disease-endemic countries and to consider implementation of appropriate screening procedures in countries where the disease is not endemic;
- (7) to strengthen and harmonize public health policies to reduce the burden of Chagas disease, particularly in countries where the disease is not endemic;
  - (8) to promote the development of public health measures in disease-endemic and non-endemic countries, with special focus on endemic areas, for the prevention of transmission through blood transfusion and organ transplantation, early diagnosis of congenital transmission and management of cases;
  - (9) to integrate, at the primary health-care level, diagnosis and treatment of Chagas disease in patients in both acute and chronic phases of the disease;
2. REQUESTS the Director-General:
- (1) to draw attention to the burden of Chagas disease and to the need to provide equitable access to medical services for the management and prevention of the disease;
  - (2) to strengthen implementation of vector-control activities in order to achieve interruption of domestic transmission of *Trypanosoma cruzi* and to promote research to improve or develop new prevention strategies;
  - (3) to promote in areas endemic for Chagas disease action to detect infected donors at blood banks in order to integrate strategies for safe blood;
  - (4) to provide support to the countries of the Americas in order to strengthen intergovernmental initiatives and the technical secretariat of the Pan American Sanitary Bureau as a successful form of technical cooperation among countries, and to consider an initiative for the prevention and control of Chagas disease in non-endemic regions;
  - (5) to collaborate with Member States and intergovernmental initiatives with the aim of setting objectives and goals for the interruption of transmission, particularly for domestic vectorial transmission in Latin American countries;
  - (6) to support the mobilization of national and international, public and private financial and human resources to ensure achievement of the goals;
  - (7) to promote research related to prevention, control and care of Chagas disease;
  - (8) to promote intersectoral efforts and collaboration, and facilitate networking between organizations and partners interested in supporting the development and the strengthening of Chagas disease-control programmes;

(9) to report on progress in the elimination of Chagas disease to the Sixty-fifth World Health Assembly through the Executive Board.

(Eighth plenary meeting, 21 May 2010 –  
Committee A, fifth report)

### **WHA63.21 WHO's role and responsibilities in health research<sup>1</sup>**

The Sixty-third World Health Assembly,

Having considered the draft of the WHO strategy on research for health;<sup>2</sup>

Recalling resolution WHA58.34 on the Ministerial Summit on Health Research and resolution WHA60.15 on WHO's role and responsibilities in health research;

Recognizing the contribution of research to the development of solutions to health problems and the advancement of health worldwide;

Aware that, in a rapidly changing world facing significant environmental, demographic, social and economic challenges, research will be increasingly essential for clarifying the nature and scope of health problems, and for identifying effective life-saving interventions and strategies;

Realizing the increasingly multidisciplinary and intersectoral nature of research for health improvement;

Affirming the roles and responsibilities of WHO, as the leading global health organization, in health research;

Recognizing the need to strengthen the capacity of the public sector in health research;

Acknowledging that research activities in the private and public sectors can be mutually supportive and complementary in improving health globally;

Conscious of the need to strengthen the conduct, management and coordination of WHO's activities in health research;

Cognizant of the need to better communicate WHO's research activities and results, especially to its Member States and partners;

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<sup>1</sup> For financial and administrative implications for the Secretariat of this resolution, see document A63/22 Add.1.

<sup>2</sup> Document A63/22.

Noting the references to research for health in resolution WHA61.21 on the Global strategy and plan of action on public health, innovation and intellectual property and relevant conclusions and recommendations of the WHO Commission on Social Determinants for Health;

Taking into account the outcomes of the Global Ministerial Forum on Research for Health (Bamako, 17–19 November 2008),

1. ENDORSES the WHO strategy on research for health;<sup>1</sup>
2. URGES Member States:
  - (1) to recognize the importance of research for improving health and health equity and to adopt and implement policies for research for health that are aligned with national health plans, that include the participation of all relevant sectors, public and private, that align external support around mutual priorities, and that strengthen key national institutions;
  - (2) to consider drawing on the WHO strategy on research for health according to their own national circumstances and contexts, and as part of their overall policies on health and health research;
  - (3) to strengthen national health research systems by improving the leadership and management of research for health, focusing on national needs, establishing effective institutional mechanisms for research, using evidence in health policy development, and harmonizing and coordinating national and external support (including that of WHO);
  - (4) to establish, as necessary and appropriate, governance mechanisms for research for health, to ensure rigorous application of good research norms and standards, including protection for human subjects involved in research, and to promote an open dialogue between policy-makers and researchers on national health needs, capacities and constraints;
  - (5) to improve the collection of reliable health information and data and to maximize, where appropriate, their free and unrestricted availability in the public domain;
  - (6) to promote intersectoral collaboration and high-quality research in order to produce the evidence necessary for ensuring that policies adopted in all sectors contribute to improving health and health equity;
  - (7) to initiate or strengthen intercountry collaboration with the aim of obtaining efficiencies of scale in research through the sharing of experiences, best practices and resources, the pooling of training and procurement mechanisms, and the use of common, standardized evaluation methods for research;
  - (8) to consider, where appropriate, establishment of regional collaborating mechanisms, such as centres of excellence, in order to facilitate access by Member States to the necessary research and expertise to meet health challenges;
  - (9) to continue to pursue financing of research for health as articulated in resolution WHA58.34 on the Ministerial Summit on Health Research;

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<sup>1</sup> See Annex 7.

3. INVITES Member States, the health research community, international organizations, supporters of research, the private sector, civil society and other concerned stakeholders:

- (1) to provide support to the Secretariat in implementing the WHO strategy on research for health and in monitoring and evaluating its effectiveness;
- (2) to collaborate with the Secretariat, within the framework of the strategy, in identifying priorities for research for health, in developing guidelines relating to research for health and in the collection of health information and data;
- (3) to assist the Secretariat and WHO's research partners in mobilizing enhanced resources for the identified global priorities for research for health;
- (4) to pay particular attention to the research needs of low-income countries, notably in areas such as technology transfer, research workforce, and infrastructure development and the determinants of health particularly where this will contribute to the achievement of the Millennium Development Goals, health equity and better health for all and to collaborate with WHO's Member States and the Secretariat to better align and coordinate the global health research architecture and its governance through the rationalization of existing global health research partnerships, to improve coherence and impact, and to increase efficiencies and equity;
- (5) to support, where appropriate, technical cooperation among developing countries in research for health;

4. REQUESTS the Director-General:

- (1) to provide leadership in identifying global priorities for research for health;
- (2) to implement the WHO strategy on research for health within the Organization at all levels and with partners, and in line with the references to research for health in the Global strategy and plan of action on public health, innovation and intellectual property;
- (3) to improve the quality of research within the Organization;
- (4) to provide adequate core resources in proposed programme budgets for the implementation of the WHO strategy on research for health;
- (5) to ensure that the highest norms and standards of good research are upheld within WHO, including technical, ethical and methodological aspects and the translation into practice, use and dissemination of results and to review and align the architecture and governance of the Organization's research activities and partnerships;
- (6) to provide support to Member States, upon request and as resources permit, in taking relevant actions to strengthen national health research systems and intersectoral collaborations, including capacity building in order to create a sustainable critical mass of health systems and health policy researchers in developing countries;
- (7) to strengthen the role of WHO collaborating centres as a well-established, effective mechanism for cooperation between the Organization and countries in the field of research for health;



(8) to report to the Sixty-fifth World Health Assembly on the implementation of this resolution, through the Executive Board.

(Eighth plenary meeting, 21 May 2010 –  
Committee A, fifth report)

## **WHA63.22 Human organ and tissue transplantation<sup>1</sup>**

The Sixty-third World Health Assembly,

Having considered the report on human organ and tissue transplantation;<sup>2</sup>

Recalling resolutions WHA40.13, WHA42.5 and WHA44.25 on organ procurement and transplantation and WHA57.18 requesting an update of the Guiding Principles on Human Organ Transplantation;

Aware of the growing magnitude and utility of human cell, tissue and organ transplantation for a wide range of conditions in low-resource as well as high-resource countries;

Committed to the principles of human dignity and solidarity which condemn the buying of human body parts for transplantation and the exploitation of the poorest and most vulnerable populations and the human trafficking that result from such practices;

Determined to prevent harm caused by the seeking of financial gain or comparable advantage in transactions involving human body parts, including organ trafficking and transplant tourism;

Convinced that the voluntary, non-remunerated donation of organs, cells and tissues from deceased and living donors helps to ensure a vital community resource;

Conscious of the extensive cross-boundary circulation of cells and tissues for transplantation;

Sensitive to the need for post-transplantation surveillance of adverse events and reactions associated with the donation, including long-term follow up of the living donor, processing and transplantation of human cells, tissues and organs as such and for international exchange of such data to optimize the safety and efficacy of transplantation,

1. ENDORSES the WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation;<sup>3</sup>
2. URGES Member States:<sup>4</sup>

(1) to implement the WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation in the formulation and enforcement of their own policies, laws and legislation regarding human cell, tissue and organ donation and transplantation where appropriate;

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<sup>1</sup> For financial and administrative implications for the Secretariat of this resolution, see document A63/24 Add.1.

<sup>2</sup> Document A63/24.

<sup>3</sup> See Annex 8.

<sup>4</sup> And, where appropriate, regional economic international organizations.

(2) to promote the development of systems for the altruistic voluntary non-remunerated donation of cells, tissues and organs as such, and increase public awareness and understanding of the benefits as a result of the voluntary non-remunerated provision of cells, tissues and organs as such from deceased and living donors, in contrast to the physical, psychological and social risks to individuals and communities caused by trafficking in material of human origin and transplant tourism;

(3) to oppose the seeking of financial gain or comparable advantage in transactions involving human body parts, organ trafficking and transplant tourism, including by encouraging health-care professionals to notify relevant authorities when they become aware of such practices in accordance with national capacities and legislation;

(4) to promote a system of transparent, equitable allocation of organs, cells and tissues, guided by clinical criteria and ethical norms, as well as equitable access to transplantation services in accordance with national capacities, which provides the foundation for public support of voluntary donation;

(5) to improve the safety and efficacy of donation and transplantation by promoting international best practices;

(6) to strengthen national and multinational authorities and/or capacities to provide oversight, organization and coordination of donation and transplantation activities, with special attention to maximizing donation from deceased donors and to protecting the health and welfare of living donors with appropriate health-care services and long-term follow up;

(7) to collaborate in collecting data including adverse events and reactions on the practices, safety, quality, efficacy, epidemiology and ethics of donation and transplantation;

(8) to encourage the implementation of globally consistent coding systems for human cells, tissues and organs as such in order to facilitate national and international traceability of materials of human origin for transplantation;

3. REQUESTS the Director-General:

(1) to disseminate the WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation as widely as possible to all interested parties;

(2) to provide support to Member States and nongovernmental organizations in order to ban trafficking in material of human origin and transplant tourism;

(3) to continue collecting and analysing global data on the practices, safety, quality, efficacy, epidemiology and ethics of donation and transplantation of human cells, tissues and organs;

(4) to facilitate Member States' access to appropriate information on the donation, processing and transplantation of human cells, tissues and organs, including data on severe adverse events and reactions;

(5) to provide, in response to requests from Member States, technical support for developing national legislation and regulation on, and suitable and traceable coding systems for, donation and transplantation of human cells, tissues or organs, in particular by facilitating international cooperation;

(6) to review the WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation periodically in the light of national experience with their implementation and of developments in the field of transplantation of human cells, tissues and organs;

(7) to report to the Health Assembly, through the Executive Board, at least every four years on actions taken by the Secretariat, as well as by Member States, to implement this resolution.

(Eighth plenary meeting, 21 May 2010 –  
Committee A, fifth report)

### **WHA63.23 Infant and young child nutrition<sup>1</sup>**

The Sixty-third World Health Assembly,

Having considered the report on infant and young child nutrition;<sup>2</sup>

Recalling resolutions WHA33.32, WHA34.22, WHA35.26, WHA37.30, WHA39.28, WHA41.11, WHA43.3, WHA45.34, WHA46.7, WHA47.5, WHA49.15, WHA54.2, WHA55.25, WHA58.32, WHA59.21 and WHA61.20 on infant and young child nutrition, and on nutrition and HIV/AIDS and the Codex Alimentarius Guidelines for use of nutrition and health claims;<sup>3</sup>

Conscious that achieving the Millennium Development Goals will require the reduction of maternal and child malnutrition;

Aware that worldwide malnutrition accounts for 11% of the global burden of disease, leading to long-term poor health and disability and poor educational and developmental outcomes; that worldwide 186 million children are stunted<sup>4</sup> and 20 million suffer from the most deadly form of severe acute malnutrition each year; and that nutritional risk factors, including underweight, suboptimal breastfeeding and vitamin and mineral deficiencies, particularly of vitamin A, iron, iodine and zinc, are responsible for 3.9 million deaths (35% of total deaths) and 144 million disability-adjusted life years (33% of total disability-adjusted life years) in children less than five years old;

Aware that countries are faced with increasing public health problems posed by the double burden of malnutrition (both undernutrition and overweight), with its negative later-life consequences;

Acknowledging that 90% of stunted children live in 36 countries and that children under two years of age are most affected by undernutrition;

Recognizing that the promotion of breast-milk substitutes and some commercial foods for infants and young children undermines progress in optimal infant and young child feeding;

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<sup>1</sup> For financial and administrative implications for the Secretariat of this resolution, see document EB126/2010/REC/1, Annex 7.

<sup>2</sup> Document A63/9.

<sup>3</sup> Document CAC/GL/23.

<sup>4</sup> *World health statistics, 2010*. World Health Organization, Geneva, 2010.

Mindful of the challenges posed by the HIV/AIDS pandemic and the difficulties in formulating appropriate policies for infant and young child feeding, and concerned that food assistance does not meet the nutritional needs of young children infected by HIV;

Concerned that in emergencies, many of which occur in countries not on track to attain Millennium Development Goal 4 and which include situations created by the effects of climate change, infants and young children are particularly vulnerable to malnutrition, illness and death;

Recognizing that national emergency preparedness plans and international emergency responses do not always cover protection, promotion and support of optimal infant and young child feeding;

Expressing deep concern over persistent reports of violations of the International Code of Marketing of Breast-milk Substitutes by some infant food manufacturers and distributors with regard to promotion targeting mothers and health-care workers;

Expressing further concern over reports of the ineffectiveness of measures, particularly voluntary measures, to ensure compliance with the International Code of Marketing of Breast-milk Substitutes in some countries;

Aware that inappropriate feeding practices and their consequences are major obstacles to attaining sustainable socioeconomic development and poverty reduction;

Concerned about the vast numbers of infants and young children who are still inappropriately fed and whose nutritional status, growth and development, health and survival are thereby compromised;

Mindful of the fact that implementation of the global strategy for infant and young child feeding and its operational targets requires strong political commitment and a comprehensive approach, including strengthening of health systems and communities with particular emphasis on the Baby-friendly Hospital Initiative, and careful monitoring of the effectiveness of the interventions used;

Recognizing that the improvement of exclusive breastfeeding practices, adequate and timely complementary feeding, along with continued breastfeeding for up to two years or beyond, could save annually the lives of 1.5 million children under five years of age;

Aware that multisectoral food and nutrition policies are needed for the successful scaling up of evidence-based safe and effective nutrition interventions;

Recognizing the need for comprehensive national policies on infant and young child feeding that are well integrated within national strategies for nutrition and child survival;

Convinced that it is time for governments, civil society and the international community to renew their commitment to promoting the optimal feeding of infants and young children and to work together closely for this purpose;

Convinced that strengthening of national nutrition surveillance is crucial in implementing effective nutrition policies and scaling up interventions,

1. URGES Member States:

- (1) to increase political commitment in order to prevent and reduce malnutrition in all its forms;

- (2) to strengthen and expedite the sustainable implementation of the global strategy for infant and young child feeding including emphasis on giving effect to the aim and principles of the International Code of Marketing of Breast-milk Substitutes, and the implementation of the Baby-friendly Hospital Initiative;
- (3) to develop and/or strengthen legislative, regulatory and/or other effective measures to control the marketing of breast-milk substitutes in order to give effect to the International Code of Marketing of Breast-milk Substitutes and relevant resolution adopted by the World Health Assembly;
- (4) to end inappropriate promotion of food for infants and young children, and to ensure that nutrition and health claims shall not be permitted for foods for infants and young children, except where specifically provided for in relevant Codex Alimentarius standards or national legislation;
- (5) to develop or review current policy frameworks for addressing the double burden of malnutrition, to include in the frameworks childhood obesity and food security, and to allocate adequate human and financial resources to ensure implementation of those policies;
- (6) to scale up interventions to improve infant and young child nutrition in an integrated manner with the protection, promotion and support of breastfeeding and timely, safe and appropriate complementary feeding as core interventions; the implementation of interventions for the prevention and management of severe malnutrition; and the targeted control of vitamin and mineral deficiencies;
- (7) to consider and implement, as appropriate the revised principles and recommendations on infant feeding in the context of HIV, issued by WHO in 2009,<sup>1</sup> in order to address the infant feeding dilemma for HIV-infected mothers and their families while ensuring protection, promotion and support of exclusive and sustained breastfeeding for the general population;
- (8) to ensure that national and international preparedness plans and emergency responses follow the evidence-based Operational Guidance for Emergency Relief Staff and Programme Managers<sup>2</sup> on infant and young child feeding in emergencies, which includes the protection, promotion and support for optimal breastfeeding, and the need to minimize the risks of artificial feeding, by ensuring that any required breast-milk substitutes are purchased, distributed and used according to strict criteria;
- (9) to include the interventions referred to in subparagraph 1(6) above in comprehensive maternal and child health services and support the aim of universal coverage and principles of primary health care, including strengthening health systems as outlined in resolution WHA62.12;
- (10) to strengthen nutrition surveillance systems and improve use and reporting of agreed Millennium Development Goals indicators in order to monitor progress;
- (11) to implement the WHO Child Growth Standards by their full integration into child health programmes;

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<sup>1</sup> *Rapid advice: revised principles and recommendations in the context of HIV, November 2009*. Geneva, World Health Organization, 2009.

<sup>2</sup> Available online at <http://www.enonline.net/resources/6>.

(12) to implement the measures for prevention of malnutrition as specified in the WHO strategy for community-based management of severe acute malnutrition,<sup>1</sup> most importantly improving water and sanitation systems and hygiene practices to protect children against communicable disease and infections;

2. CALLS UPON infant food manufacturers and distributors to comply fully with their responsibilities under the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions;

3. REQUESTS the Director-General:

(1) to strengthen the evidence base on effective and safe nutrition actions to counteract the public health effects of the double burden of malnutrition, and to describe good practices for successful implementation;

(2) to mainstream nutrition in all WHO's health policies and strategies and confirm the presence of essential nutrition actions, including integration of the revised principles and recommendations on infant feeding in the context of HIV, issued by WHO in 2009, in the context of the reform of primary health care;

(3) to continue and strengthen the existing mechanisms for collaboration with other United Nations agencies and international organizations involved in the process of ensuring improved nutrition including clear identification of leadership, division of labour and outcomes;

(4) to support Member States, on request, in expanding their nutritional interventions related to the double burden of malnutrition, monitoring and evaluating impact, strengthening or establishing effective nutrition surveillance systems, and implementing the WHO Child Growth Standards, and the Baby-friendly Hospital Initiative;

(5) to support Member States, on request, in their efforts to develop and/or strengthen legislative, regulatory or other effective measures to control marketing of breast-milk substitutes;

(6) to develop a comprehensive implementation plan on infant and young child nutrition as a critical component of a global multisectoral nutrition framework for preliminary discussion at the Sixty-fourth World Health Assembly and for final delivery at the Sixty-fifth World Health Assembly, through the Executive Board and after broad consultation with Member States.

(Eighth plenary meeting, 21 May 2010 –  
Committee A, fifth report)

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<sup>1</sup> *Community-based management of severe acute malnutrition: a joint statement by the World Health Organization, the World Food Programme, the United Nations System Standing Committee on Nutrition and the United Nations Children's Fund.* Geneva, World Health Organization, 2007.

**WHA63.24 Accelerated progress towards achievement of Millennium Development Goal 4 to reduce child mortality: prevention and treatment of pneumonia<sup>1</sup>**

The Sixty-third World Health Assembly,

Having considered the report on treatment and prevention of pneumonia;<sup>2</sup>

Aware of the joint WHO/UNICEF report on a global action plan for the prevention and control of pneumonia, presented in November 2009;<sup>3</sup>

Noting the first advance market commitment on the pneumococcal vaccine and the progress made so far in integrating the *Haemophilus influenzae* type b vaccine into routine immunization programmes;

Noting also the introduction of the pneumococcal Accelerated Development and Introduction Plans;

Recalling that in resolution WHA58.15 on the global immunization strategy the Health Assembly requested the Director-General to mobilize resources to promote the availability and affordability in countries of future new vaccines based on evidence of epidemiological profiles;

Concerned at the lack of substantial progress towards reducing morbidity and mortality from pneumonia, despite it being globally the leading cause of mortality of children under the age of five years;

Mindful that decreasing the global burden of pneumonia will be essential for reaching Target 4.A of Millennium Development Goal 4;

Noting that safe and highly effective tools are available for pneumonia control in the form of WHO's Integrated Management of Childhood Illness approach for case management at all levels, universal childhood immunization against *Haemophilus influenzae* type b and *Streptococcus pneumoniae* infections, improvement of nutrition and low birth weight, control of indoor air pollution arising from household use of solid fuels and second-hand smoking in households, and prevention and management of HIV infection;

Further noting that affordable price of vaccines in preventing pneumonia and significant scaling up of cold-chain capacities determine the adoption and implementation of vaccination programmes particularly in developing countries;

Concerned that pneumonia continues to cause more than 1.8 million preventable deaths in children less than five years of age globally each year;

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<sup>1</sup> For financial and administrative implications for the Secretariat of this resolution, see document EB126/2010/REC/1, Annex 7.

<sup>2</sup> Document A63/26.

<sup>3</sup> Document WHO/FCH/CAH/NCH/09.04.

Noting that the GAVI Alliance and other donors have made substantial resources available, and that the International Finance Facility for Immunisation and the PAHO revolving fund for immunization provide powerful mechanisms for directing resources to immunization programmes;

Welcoming the contribution to the mobilization of resources for development of voluntary innovative financing initiatives taken by groups of Member States;

Noting in addition that efforts to strengthen the capacity of health systems to detect and manage pneumonia effectively are likely also to contribute positively to efforts to achieve Millennium Development Goal 5 (Improve maternal health);

Aware that pandemic (H1N1) 2009 has raised awareness of the need for system-wide strengthening of management of serious acute respiratory infections, and noting that the time is therefore opportune to build upon investments made related to the pandemic and to continue efforts to ensure that patients with acute respiratory infections receive prompt and effective treatment,

1. URGES Member States:

- (1) to apply, according to their specific contexts, the policies, strategies and tools recommended by WHO to prevent and treat pneumonia;
- (2) to establish evidence-based national policies and operational plans for strengthening health systems in order to expand coverage of populations at risk with effective preventive and curative interventions;
- (3) to assess programme performance including the coverage and impact of interventions in an effective and timely manner, and use this assessment to inform WHO's country-profile database;
- (4) to identify national and international resources, both human and financial, for strengthening health systems and for the provision of technical support in order to ensure that the most locally and epidemiologically appropriate strategies are implemented and target populations reached;
- (5) to implement the recommendations in the joint WHO/UNICEF global action plan for the prevention and control of pneumonia, noting the importance of:
  - (a) integrated case management at community, health-centre and hospital levels;
  - (b) immunization by accelerating the adoption of affordable and cost-effective vaccines based on evidence of national epidemiological profiles;
  - (c) exclusive breastfeeding for six months;
  - (d) improvement of nutrition and prevention of low birth weight;
  - (e) control of indoor air pollution;
  - (f) prevention and management of HIV infection;
- (6) to encourage integrated approaches to pneumonia prevention and treatment through multisectoral collaboration and community responsibility and participation;



2. REQUESTS the Director-General:

(1) to strengthen human resources for prevention and control of pneumonia at all levels, especially the country level, thereby improving the capacity of WHO's country offices to provide support to national health programmes for coordinating the work of partners on preventing and controlling pneumonia;

(2) to bring together interested Member States, organizations in the United Nations system, the GAVI Alliance, medical research councils, and other interested stakeholders in a forum in order to improve coordination between different stakeholders in the fight against pneumonia and mobilize resources to promote the availability and affordability of *Haemophilus influenzae* type b and pneumococcal vaccines;

(3) to expand the coverage of the report to the Health Assembly through the Executive Board on the status of progress made in achieving the health-related Millennium Development Goals, requested in resolution WHA61.18, to include progress on the implementation of this resolution, starting from the Sixty-fourth World Health Assembly.

(Eighth plenary meeting, 21 May 2010 –  
Committee A, fifth report)

**WHA63.25 Improvement of health through safe and environmentally sound waste management<sup>1</sup>**

The Sixty-third World Health Assembly,

Having considered the report on the Strategic Approach to International Chemicals Management;<sup>2</sup>

Recalling resolution WHA61.19 on climate change and health, and resolutions WHA59.15, WHA50.13, WHA45.32, WHA31.28 and WHA30.47 relating to chemical safety;

Recalling also resolutions of the United Nations General Assembly 44/226 of 22 December 1989 on traffic in and disposal, control and transboundary movements of toxic and dangerous products and wastes and 43/212 of 20 December 1988 on the responsibility of States for the protection of the environment;

Noting the principles set out in Agenda 21, including chapter 20 and chapter 21, as agreed upon at the United Nations Conference on Environment and Development in 1992;

Noting also the Johannesburg Declaration on Sustainable Development and the related Plan of Implementation of the World Summit on Sustainable Development in 2002;

Acknowledging decision 25/8 on Waste Management adopted by the Governing Council/Global Ministerial Environment Forum of the United Nations Environment Programme at its 25th session;

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<sup>1</sup> For financial and administrative implications for the Secretariat of this resolution, see document EB126/2010/REC/1, Annex 7.

<sup>2</sup> Document A63/21.

Mindful of the outcomes of the second session of the International Conference on Chemicals Management which relate to human health;

Aware that wastes, if not properly managed in a safe and environmentally sound manner, may have serious consequences for human health and livelihood;

Convinced that the lack of environmentally sound management of waste will harm the environment and be detrimental to human health, through polluted air, water, land and food chains;

Concerned that poor management of health-care waste, including sharps, non-sharp materials, blood, body parts, chemicals, pharmaceuticals and medical devices, puts health-care workers, waste handlers and the community at risk of infections, toxic effects and injuries;

Welcoming the Bali Declaration on Waste Management for Human Health and Livelihood adopted at the ninth meeting of the Conference of the Parties to the Basel Convention on the Control of Transboundary Movement of Hazardous Wastes and their Disposal in 2008,

1. URGES Member States<sup>1</sup> to apply the Health Impact Assessment as one of the key tools to assess the health aspects of waste management in order to make it safe and environmentally sound and to explore options to work more closely with the United Nations Environment Programme, the Strategic Approach to International Chemicals Management, the Basel Convention on the Control of Transboundary Movement of Hazardous Wastes and their Disposal and the WHO Secretariat towards achieving their shared objectives on the improvement of health through safe and environmentally sound waste management;

2. REQUESTS the Director-General:

(1) to support the implementation of the actions set out in the Bali Declaration on Waste Management for Human Health and Livelihood, within WHO's mandate and available resources;

(2) to work together with the United Nations Environment Programme and the secretariat of the Basel Convention on the Control of Transboundary Movement of Hazardous Wastes and their Disposal on environmentally sound waste management, including collaborating with governments and donor organizations to strengthen the implementation of the Bali Declaration on Waste Management for Human Health and Livelihood, with the aim in particular of:

(a) promoting the raising of awareness about the link between waste management, health and livelihood, and the environment;

(b) strengthening subregional and regional cooperation on waste and health issues by promoting human and appropriate technical capacities at national, regional and international levels;

(c) improving controls on waste shipment and border procedures in order to prevent illegal movements of hazardous and other wastes, through means that include capacity building, technology transfer and technical assistance;

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<sup>1</sup> And, where applicable, regional economic integration organizations.

- (d) improving cooperation between national authorities in the waste, chemicals and health sectors and, in collaboration with other relevant authorities and stakeholders, in the development and implementation of effective and sound waste management systems;
- (e) increasing capacity building, promoting and, where possible, enhancing public and private investment for the transfer and use of appropriate technology for safe and environmentally sound waste management;
- (3) to continue supporting the prevention of health risks associated with exposure to health-care waste and promoting environmentally sound management of health-care waste in order to support the work of the Basel Convention on the Control of Transboundary Movement of Hazardous Wastes and their Disposal and the Stockholm Convention on Persistent Organic Pollutants;
- (4) to explore the development of strategies aimed at minimizing the generation of health-care waste;
- (5) to invite governments, relevant intergovernmental and regional economic integration organizations, relevant entities of the industry and business sectors and civil society to provide resources and technical assistance to developing countries in designing and implementing strategies and approaches to improve health through safe and environmentally sound waste management;
- (6) to report to the Sixty-fourth World Health Assembly, through the Executive Board, on implementation of this resolution.

(Eighth plenary meeting, 21 May 2010 –  
Committee A, fifth report)

**WHA63.26      Improvement of health through sound management of obsolete pesticides and other obsolete chemicals<sup>1</sup>**

The Sixty-third World Health Assembly,

Having considered the report on the Strategic Approach to International Chemicals Management,<sup>2</sup>

Recalling resolution WHA59.15 on the Strategic Approach to International Chemicals Management;

Recognizing the outcomes of the second session of the International Conference on Chemicals Management (Geneva, 11–15 May 2009) regarding human health and, in particular, resolution II/8 on health aspects of the sound management of chemicals which drew attention to the need for a greater involvement of health sector, Member States<sup>3</sup> and the WHO Secretariat in the implementation of the

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<sup>1</sup> For financial and administrative implications for the Secretariat of this resolution, see document EB126/2010/REC/1, Annex 7.

<sup>2</sup> Document A63/21.

<sup>3</sup> And, where applicable, regional economic integration organizations.

Global Plan of Action of the Strategic Approach to International Chemicals Management<sup>1</sup> because of the adverse effects some chemicals may have on human health, and noting that some of the global priorities for cooperative action identified within the Strategic Approach to International Chemicals Management also have to be dealt with by the health sector;

Recognizing that pesticides are designed to kill or control harmful organisms and pests, and may have adverse acute and chronic effects, and that, although they are regulated in most countries, they may affect populations' health and the environment, particularly when improperly used and stored, including when they are obsolete;<sup>2</sup>

Recalling WHO's Constitution, and recognizing the following relevant international agreements and instruments: the Bali Declaration on Waste Management for Human Health and Livelihood (2008), the United Nations Conference on Environment and Development (Rio de Janeiro, Brazil, 1992), the World Summit on Sustainable Development (Johannesburg, South Africa, 2002), the adoption of the Strategic Approach to International Chemicals Management by the International Conference on Chemicals Management (Dubai, 2006), the Basel Convention on the Control of the Transboundary Movements of Hazardous Wastes and their Disposal (1989), the Rotterdam Convention on the Prior Informed Consent Procedure for Certain Hazardous Chemicals and Pesticides in International Trade (2004, revised 2008), the Stockholm Convention on Persistent Organic Pollutants (Stockholm, 2004), and the Convention on the Prevention of Marine Pollution by Dumping of Wastes and Other Matter 1972 and 1996 Protocol Thereto (London 1972), and the International Health Regulations (2005);

Recognizing that all the forums, conventions and instruments mentioned in the preceding paragraph are important global tools for the preservation and protection of human health and the environment that provide measures and guidelines to deal with certain aspects of chemicals' life-cycle, and that, in that sense, the closely linked Stockholm Convention on Persistent Organic Pollutants and Basel Convention on the Control of the Transboundary Movements of Hazardous Wastes and their Disposal<sup>3</sup> foresee the development of appropriate strategies for identification of persistent organic pollutant wastes, stockpiles of persistent organic pollutants and their management;

Recognizing that hazardous waste and highly toxic pesticides fall under the global priority areas identified for cooperative action within the Strategic Approach to International Chemicals Management, and that the Health Assembly in resolution WHA59.15 on Strategic Approach to International Chemicals Management urged Member States to participate in national, regional and international efforts to implement the Strategic Approach;

Mindful of the new challenges and determinants of health and of the need for additional action in order to preserve and protect human health and the environment;

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<sup>1</sup> Document WHA59/2006/REC/1, Annex 1.

<sup>2</sup> The International HCH and Pesticides Association (IHPA) estimates that total amount of obsolete pesticides is about 260 000–265 000 tonnes in central and eastern Europe and the countries of the former Union of Soviet Socialist Republics. Estimated amounts in 25 Member States of the European Union are 22 000–24 000 tonnes, south-east Europe 36 000–41 000 tonnes, the countries of the former Union of Soviet Socialist Republics 199 000 tonnes, Africa 50 000 tonnes (estimated by FAO in its Africa Stockpiles Programme), South-East Asia 6500 tonnes (FAO, first rough indication), Central and South America 30 000 tonnes (FAO, 2005).

<sup>3</sup> The fundamental aims of the Basel Convention are the control and reduction of transboundary movement of hazardous and other wastes subject to the Convention, the prevention and minimization of their generation, the environmentally sound management of such wastes and active promotion of the transfer and use of cleaner technologies.

Recognizing the risks to human health and environment from obsolete pesticides and other obsolete chemicals, particularly through local and global chemical accidents and disasters;

Recognizing also the risks to human health and environment from obsolete pesticides and other obsolete chemicals, linked to the creation of stockpiles resulting from their regulation (such as withdrawal from the market without appropriate phase-out period) or inherited from past periods of pesticides over-consumption, which might further lead to spreading of improperly stored chemicals worldwide;

Recalling the fact that the exposure of humans and the environment to obsolete pesticides and other obsolete chemicals may also be due to their long-range transport;

Recognizing that the threat of unsafe storage of obsolete pesticides and other obsolete chemicals, may, owing to illegal use, package deterioration, or accidents, cause localized or widespread pollution and represent a potential risk to human health and the environment;

Mindful of the clear evidence that, besides environmental benefits, health benefits can be expected from safe and efficient handling and disposal of obsolete pesticides and other obsolete chemicals;

Acknowledging the progress regarding obsolete pesticides made by African countries through the interagency Africa Stockpiles Programme with the support of FAO, the Global Environment Facility, the World Bank and other partners;

Welcoming the work of the Basel Convention on the Control of the Transboundary Movements of Hazardous Wastes and their Disposal in developing technical guidelines on the environmentally sound disposal of wastes containing persistent organic pollutants;

Further recognizing that only a comprehensive and long-term strategy of sound management of obsolete pesticides and other obsolete chemicals can be effective,

1. URGES Member States:<sup>1</sup>

(1) to adopt, where necessary, or strengthen sound national policies and legislation on safe handling and disposal of obsolete pesticides and other obsolete chemicals;

(2) to adopt, where this has not already been done in the context of the Stockholm Convention on Persistent Organic Pollutants and other existing instruments, comprehensive national implementation plans or other strategies as the basis for taking action towards the elimination of risks from obsolete pesticides and other obsolete chemicals;

(3) to enhance social responsibility through awareness-raising in the area of obsolete pesticides and other obsolete chemicals and chemicals with potential transboundary risks to human health;

(4) to increase support for training and capacity building, and coordinated technical activities for implementing relevant international conventions and instruments;

(5) to encourage and promote cooperation between Member States in this regard;

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<sup>1</sup> And, where applicable, regional economic integration organizations.

(6) to establish or strengthen capacity for the regulation of the sound management of pesticides and other chemicals throughout their life-cycle, as a preventive measure to avoid accumulation of obsolete chemicals;

2. INVITES all relevant stakeholders, including Member States, regional economic integration organizations, bodies in the United Nations system and other intergovernmental organizations including regional, international and national nongovernmental organizations and foundations, waste-management companies, pesticide manufacturers, donors and the remaining international community:

(1) to promote sound management of obsolete pesticides and other obsolete chemicals in order to minimize and, wherever possible, avoid adverse impacts to human health and the environment;

(2) to mobilize efforts and cooperate with other stakeholders in the implementation of national implementation plans and strategies, through local, regional and global networks among other means;

(3) to consider the synergies to be gained from sharing technical experience, expertise and capacity-building efforts among international instruments, conventions, regulations and processes;

3. REQUESTS the Director-General:

(1) to support the development of appropriate and efficient strategies (at national, regional and international levels) for minimizing the risks of obsolete pesticides and other obsolete chemicals and thus promote the relevant WHO policy goals and practices;

(2) to enhance WHO's capacity to foster the strategies mentioned in subparagraph 3(1) above;

(3) to facilitate implementation of the strategies on sound management of obsolete pesticides and other obsolete chemicals with a view to reducing inequities in health and securing an unpolluted living environment;

(4) to work with UNEP, in connection with the WHO/UNEP Health Environment Linkages Initiative and the Strategic Approach to International Chemicals Management, as well as with UNDP, FAO, the World Bank and other appropriate institutions in assisting Member States to implement their national strategies and existing guidance, for instance under the Basel Convention on the Control of the Transboundary Movements of Hazardous Wastes and their Disposal<sup>1</sup> and strategies for sound management of obsolete pesticides and other obsolete chemicals at the global level;

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<sup>1</sup> Technical guidelines on the safe disposal of obsolete pesticides  
(<http://www.basel.int/meetings/sbc/workdoc/techdocs.html>):

- Updated general technical guidelines for the environmentally sound management of wastes consisting of, containing or contaminated with persistent organic pollutants,
- Technical guidelines for the environmentally sound management of wastes consisting of, containing or contaminated with 1,1,1-trichloro-2,2-bis(4-chlorophenyl)ethane (DDT),
- Technical guidelines on the environmentally sound management of wastes consisting of, containing or contaminated with the pesticides aldrin, chlordane, dieldrin, endrin, heptachlor, hexachlorobenzene (HCB), mirex or toxaphene or with HCB as an industrial chemical.

- (5) to include obsolete pesticides and other obsolete chemicals among WHO's priorities in order to reduce and prevent risks to human health and the environment from their adverse effects and to support their safe disposal;
- (6) to ensure full support of WHO to the activities of the secretariat of the Strategic Approach to International Chemicals Management;
- (7) to support the ongoing joint efforts of FAO and WHO in capacity building of Member States in the sound management of pesticides;
- (8) to report to the Sixty-fourth World Health Assembly, through the Executive Board, on progress in implementing this resolution.

(Eighth plenary meeting, 21 May 2010 –  
Committee A, fifth report)

**WHA63.27      Strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services<sup>1</sup>**

The Sixty-third World Health Assembly,

Having considered the report on strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services;<sup>2</sup>

Recognizing the variety of private providers, from faith-based and other nongovernmental non-profit organizations and individual health-care entrepreneurs, both formal and informal, to private for-profit firms and corporations, and the evidence that they play a significant and growing role in health-care delivery across the world;

Noting that governments across the world are faced with the challenge of constructive engagement with the complex range of health-care providers, in ways that vary considerably according to context;

Noting that the cost and quality of the care provided and the effect on health and social outcomes may vary considerably and that there are serious reasons for concern in environments where regulation is poor or absent, yet as a whole the documentation and evidence base in this regard is weak;

Recognizing that governments that have the institutional capacity to govern the broad range of health-care providers can play a constructive role in providing essential health services;

Concerned about evidence that in many countries effective engagement, oversight and regulation of the various private health-care providers may be constrained by imperfect strategic intelligence, limited financial influence and weak institutional capacity;

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<sup>1</sup> For financial and administrative implications for the Secretariat of this resolution, see document A63/25 Add.1.

<sup>2</sup> Document A63/25.

Aware that building trust and constructive policy dialogue are vital for successful engagement, oversight and regulation;

Noting that the renewal of primary health care provides a policy framework in which to set benchmarks for strengthened government capacity for constructive engagement with, and oversight of, both public and private health-care providers,

1. URGES Member States:

(1) to gather, by means that include improved information systems and stronger policy dialogue processes, the strategic intelligence required for: objectively assessing the positive and negative aspects of health-care delivery by private not-for-profit and private for-profit providers; identifying appropriate strategies for productive engagement; and developing regulatory frameworks that ensure universal access with social protection and the reorientation of service delivery towards people-centred primary care;

(2) to map and assess, as appropriate, the capacity and the performance of the government departments and other bodies concerned with oversight and regulation of both public and private health-care provision, including: professional councils; institutional purchasers of health services, such as public funders and state health insurance agencies, and accreditation bodies;

(3) to investigate the potential contribution to the regulation of health-care provision of non-health-sector governmental and nongovernmental entities, including health-consumer protection agencies and patient groups, and, as appropriate, set up mechanisms to maximize the value of those contributions;

(4) to build and strengthen for the long term the institutional capacity of these regulatory bodies, through adequate and sustained funding, staffing, and support;

(5) to pursue opportunities for intercountry exchange of experience with different strategies for engagement, oversight and regulation of the full range of health-care providers;

2. REQUESTS the Director-General:

(1) to provide technical assistance to Member States, upon request, in their efforts to strengthen the capacity of health ministries and other regulatory agencies in order to improve engagement with, and oversight and regulation of, the full range of public and private health-care providers;

(2) to convene technical consultations, support the research agenda set by Member States and facilitate intercountry exchange of experience in order to obtain better shared understanding and documentation of the consequences, positive and negative, of the growing diversity of health-care providers, ensuring that particular attention is given to contexts of poor regulation and to consequences in terms of health, health equity, and health systems development;

(3) also to convene technical consultations, support the research agenda set by Member States and facilitate intercountry exchange of experience in order to obtain a better shared understanding of the potential of various strategies to build the institutional capacity for regulation, oversight and harnessing entrepreneurial dynamism and sound cooperation among various types of health-care providers;



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

(Eighth plenary meeting, 21 May 2010 –  
Committee A, fifth report)

**WHA63.28 Establishment of a consultative expert working group on research and development: financing and coordination<sup>1</sup>**

The Sixty-third World Health Assembly,

Having considered the report on public health, innovation and intellectual property: global strategy and plan of action, and the report of the Expert Working Group on Research and Development: Coordination and Financing,<sup>2</sup>

Considering resolution WHA61.21 which requests the Director-General “to establish urgently a results-oriented and time-limited expert working group to examine current financing and coordination of research and development, as well as proposals for new and innovative sources of funding to stimulate research and development related to Type II and Type III diseases and the specific research and development needs of developing countries in relation to Type I diseases, and open to consideration of proposals from Member States, and to submit a progress report to the Sixty-second World Health Assembly and the final report to the Sixty-third World Health Assembly through the Executive Board”;

Noting that although the Expert Working Group made some progress in examining proposals for financing of, and coordination among, research and development activities, as called for in resolution WHA61.21, there was divergence between the expectations of Member States<sup>3</sup> and the output of the Group, underlining the importance of a clear mandate;

Considering that, in its recommendations, the Expert Working Group states the need to conduct an in-depth review of the recommended proposals;

Recognizing the need to further “explore and, where appropriate, promote a range of incentive schemes for research and development including addressing, where appropriate, the de-linkage of the costs of research and development and the price of health products, for example through the award of prizes, with the objective of addressing diseases which disproportionately affect developing countries”;<sup>4</sup>

Noting previous and ongoing work on innovative financing for health, research and development and the need to build on this work as relevant;

Emphasizing the importance of public funding of health research and development and the role of the Member States<sup>3</sup> in coordinating, facilitating and promoting health research and development;

Reaffirming the importance of other relevant actors in health research and development,

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<sup>1</sup> For financial and administrative implications for the Secretariat of this resolution, see Annex 9.

<sup>2</sup> Documents A63/6 and A63/6 Add.1, respectively.

<sup>3</sup> And, where applicable, regional economic integration organizations.

<sup>4</sup> Resolution WHA61.21, Annex, Element 5, paragraph 5.3a.

1. URGES Member States:<sup>1</sup>
  - (1) to support the work of the Consultative Expert Working Group by:
    - (a) providing, where appropriate, information, submissions or additional proposals;
    - (b) organizing and/or supporting, where appropriate, regional and subregional consultations;
    - (c) proposing names of experts for the roster;
2. REQUESTS the Director-General:
  - (1) to make available electronically by the end of June 2010:
    - (a) all the proposals considered by the Expert Working Group including their source;
    - (b) the criteria used to assess the proposals;
    - (c) the methodology used by the Expert Working Group;
    - (d) the list of the stakeholders that were interviewed and those who contributed information;
    - (e) sources of statistics used;
  - (2) to establish a Consultative Expert Working Group that shall:
    - (a) take forward the work of the Expert Working Group;
    - (b) deepen the analysis of the proposals in the Expert Working Group's report, and in particular:
      - (i) examine the practical details of the four innovative sources of financing proposed by the Expert Working Group in its report;<sup>2</sup>
      - (ii) review the five promising proposals<sup>3</sup> identified by the Expert Working Group in its report; and
      - (iii) further explore the six proposals that did not meet the criteria applied by the Expert Working Group;<sup>4</sup>
    - (c) consider additional submissions and proposals from Member States,<sup>1</sup> any regional and subregional consultations, and from other stakeholders;

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<sup>1</sup> And, where applicable, regional economic integration organizations.

<sup>2</sup> *Report of the Expert Working Group on Research and Development Financing*. Geneva, World Health Organization, 2010, Chapter 5.3.

<sup>3</sup> *Report of the Expert Working Group on Research and Development Financing*. Geneva, World Health Organization, 2010, Chapter 5.6.

<sup>4</sup> *Report of the Expert Working Group on Research and Development Financing*. Geneva, World Health Organization, 2010, Annex 2.

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- (d) in carrying out the actions in subparagraphs 2(b) and 2(c), examine the appropriateness of different research and development financing approaches and the feasibility of implementation of these approaches in each of the six WHO regions, with subregional analysis, as appropriate;
- (e) observe scientific integrity and be free from conflict of interest in its work;
- (3) to provide, upon request, within available resources dedicated to the financing of the Consultative Expert Working Group, technical and financial support for regional consultations, including meetings, in order to seek regional views to help inform the work of the Consultative Expert Working Group;
- (4) (a) to invite Member States<sup>1</sup> to nominate experts whose details, following consultations with regional committees to achieve gender balance and diversity of technical competence and expertise, shall be submitted to the Director-General through the respective regional directors;
- (b) to establish a roster of experts comprising all the nominations submitted by the regional directors;
- (c) to propose a composition of the Group to the Executive Board for its approval, drawing on the roster of experts and taking into account regional representation according to the composition of the Executive Board, gender balance and diversity of expertise;
- (d) upon approval by the Executive Board, to establish the Group and facilitate its work including its consultation with the Member States<sup>1</sup> and other relevant stakeholders, where appropriate;
- (5) to put particular emphasis on the transparent management of potential conflicts of interest by ensuring full compliance with the mechanisms established by the Director-General for that purpose;
- (6) to ensure full transparency for Member States<sup>1</sup> by providing the Consultative Expert Working Group's regular updates on the implementation of its workplan, and by making available all the documentation used by the Consultative Expert Working Group at the conclusion of the process;
- (7) to submit the workplan and inception report of the Consultative Expert Working Group to the Executive Board at its 129th session and a progress report to the Executive Board at its 130th session with a view to submitting the final report to the Sixty-fifth World Health Assembly.

(Eighth plenary meeting, 21 May 2010 –  
Committee A, fifth report)

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<sup>1</sup> And, where applicable, regional economic integration organizations.





**WHA63(4) Establishment of the General Committee**

The Sixty-third World Health Assembly elected the delegates of the following 17 countries as members of the General Committee: Burkina Faso, Cape Verde, Chad, Chile, China, Cuba, Democratic Republic of the Congo, Estonia, France, Jamaica, Jordan, Libyan Arab Jamahiriya, Russian Federation, Spain, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, United States of America.

(First plenary meeting, 17 May 2010)

**WHA63(5) Adoption of the agenda**

The Sixty-third World Health Assembly adopted the provisional agenda prepared by the Executive Board at its 126th session, with the deletion of four items and the transfer of one item from Committee B to Committee A.

(Second plenary meeting, 17 May 2010)

**WHA63(6) Verification of credentials**

The Sixty-third World Health Assembly recognized the validity of the credentials of the following delegations: Afghanistan, Albania, Algeria, Andorra, Angola, Antigua and Barbuda, Argentina, Armenia, Australia, Austria, Azerbaijan, Bahamas, Bahrain, Bangladesh, Barbados, Belarus, Belgium, Benin, Bhutan, Bolivia (Plurinational State of), Bosnia and Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Burundi, Cambodia, Cameroon, Canada, Cape Verde, Central African Republic, Chad, Chile, China, Colombia, Comoros, Congo, Cook Islands, Costa Rica, Côte d'Ivoire, Croatia, Cuba, Cyprus, Czech Republic, Democratic People's Republic of Korea, Democratic Republic of the Congo, Denmark, Djibouti, Dominican Republic, Ecuador, Egypt, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia, Fiji, Finland, France, Gabon, Gambia, Georgia, Germany, Ghana, Greece, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, Hungary, Iceland, India, Indonesia, Iran (Islamic Republic of), Iraq, Ireland, Israel, Italy, Jamaica, Japan, Jordan, Kazakhstan, Kenya, Kiribati, Kuwait, Kyrgyzstan, Lao People's Democratic Republic, Latvia, Lebanon, Lesotho, Liberia, Libyan Arab Jamahiriya, Lithuania, Luxembourg, Madagascar, Malawi, Malaysia, Maldives, Mali, Malta, Marshall Islands, Mauritania, Mauritius, Mexico, Micronesia (Federated States of), Monaco, Mongolia, Montenegro, Morocco, Mozambique, Myanmar, Namibia, Nepal, Netherlands, New Zealand, Nicaragua, Niger, Nigeria, Norway, Oman, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal, Qatar, Republic of Korea, Republic of Moldova, Romania, Russian Federation, Rwanda, Saint Lucia, Samoa, San Marino, Sao Tome and Principe, Saudi Arabia, Senegal, Serbia, Seychelles, Sierra Leone, Singapore, Slovakia, Slovenia, Solomon Islands, Somalia, South Africa, Spain, Sri Lanka, Sudan, Suriname, Swaziland, Sweden, Switzerland, Syrian Arab Republic, Tajikistan, Thailand, The former Yugoslav Republic of Macedonia, Timor-Leste, Togo, Tonga, Trinidad and Tobago, Tunisia, Turkey, Turkmenistan, Tuvalu, Uganda, Ukraine, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, United States of America, Uruguay, Uzbekistan, Vanuatu, Venezuela (Bolivarian Republic of), Viet Nam, Yemen, Zambia, Zimbabwe.

(Sixth plenary meeting, 19 May 2010)

**WHA63(7) Election of Members entitled to designate a person to serve on the Executive Board**

The Sixty-third World Health Assembly, after considering the recommendations of the General Committee, elected the following as Members entitled to designate a person to serve on the Executive Board: Armenia, Barbados, China, Ecuador, Mongolia, Morocco, Mozambique, Norway, Seychelles, Timor-Leste, United States of America, Yemen.

(Seventh plenary meeting, 20 May 2010)

**WHA63(8) United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Committee**

The Sixty-third World Health Assembly nominated Dr A.A. Yoosuf (Maldives) as a member and Mr R. Chacon (Guatemala) as an alternate member of the WHO Staff Pension Committee for a three-year term until May 2013.

(Seventh plenary meeting, 20 May 2010)

**WHA63(9) Selection of the country in which the Sixty-fourth World Health Assembly would be held**

The Sixty-third World Health Assembly, in accordance with Article 14 of the Constitution, decided that the Sixty-fourth World Health Assembly would be held in Switzerland.

(Eighth plenary meeting, 21 May 2010)

**WHA63(10) Substandard/spurious/falsely-labelled/falsified/counterfeit medical products**

The Sixty-third World Health Assembly,

Reaffirming the fundamental role of WHO in ensuring the safety, quality and efficacy of medical products;

Noting the work of WHO in ensuring safety, quality and efficacy of medical products,

1. DECIDED to establish a time-limited and results-oriented working group on substandard/spurious/falsely-labelled/falsified/counterfeit medical products comprised of and open to all Member States;<sup>1</sup>
2. REQUESTED the Director-General to convene and facilitate the work of the working group;
3. DECIDED that the working group will examine the following matters from a public health perspective, excluding trade and intellectual property considerations:

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<sup>1</sup> And, where applicable, regional economic integration organizations.

- (a) WHO's role in measures to ensure the availability of quality, safe, efficacious and affordable medical products;
- (b) WHO's relationship with the International Medical Products Anti-Counterfeiting Taskforce;
- (c) WHO's role in the prevention and control of medical products of compromised quality, safety and efficacy such as substandard/spurious/falsely-labelled/falsified/counterfeit medical products from a public health perspective, excluding trade and intellectual property considerations;
- (d) any issue or issues raised in the proposals contained in documents, A63/A/Conf.Paper No.4 Rev.1, A63/A/Conf.Paper No.5 and A63/A/Conf.Paper No.7,<sup>1</sup> starting with those issues referred to in subparagraphs (a)–(c) above;

4. DECIDED that the working group shall make specific recommendations in relation to the issues set out in paragraph 3 above and report to the Sixty-fourth World Health Assembly, and shall report on progress in implementing this decision to the Executive Board, at its 128th session.

(Eighth plenary meeting, 21 May 2010)

**Agenda item 11.20**

**A63/A/Conf.Paper No.4 Rev.1  
18 May 2010**

## **Plan of work to support the prevention and control of falsified medical products**

### **Draft resolution proposed by the delegation of Ecuador on behalf of the Union of South American Nations (UNASUR)<sup>2</sup>**

The Sixty-third World Health Assembly,

PP1 Considering resolutions WHA41.16 and WHA47.13 on the need to provide guidelines to Member States on the development of their own structures and the adoption of national measures to prevent and control falsified medical products;

PP2 Bearing in mind the Conference of Experts on the Rational Use of Drugs (Nairobi, 25–29 November 1985) which first addressed this issue at the international level;

PP3 Aware of the risks that falsified medical products entail for the population;

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<sup>1</sup> Included below.

<sup>2</sup> Argentina, Bolivia (Plurinational State of), Brazil, Chile, Colombia, Ecuador, Guyana, Paraguay, Peru, Suriname, Uruguay and Venezuela (Bolivarian Republic of).



PP4 Observing that the falsification of medical products has an international dimension and that the prevention and control of this problem necessitates cooperation at the regional and subregional levels and between countries;

PP5 Reaffirming that health authorities must perform an important function in applying health regulations that strengthen a chain of safe, high-quality and efficacious medical products,

DECIDES:

- (1) to establish an intergovernmental working group comprising delegates of Member States and the Secretariat to consider and implement cooperation at the regional and subregional levels and between countries, with a view to preventing and controlling falsified medical products from a public-health perspective, excluding commercial and intellectual property considerations;
- (2) that the working group should examine the following topics:
  - (a) education measures such as training of consumers and public-health sector stakeholders;
  - (b) measures to strengthen the chain of production and distribution of medical products, specifically in relation to regulation and inspection;
  - (c) action strategies at the national, subregional and regional levels providing for mechanisms to improve sharing of information and experiences between countries;
  - (d) strategies to improve the capacity of the health sector to apply health regulation measures;
- (3) that, with the approval of Member States, the working group should be authorized to form technical subgroups of an ad hoc and provisional nature, and to invite experts to examine specific issues.

**Agenda item 11.20**

**A63/A/Conf.Paper No.5  
19 May 2010**

## **Counterfeit medical products**

**Draft resolution proposed by the delegations of Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Equatorial Guinea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritius, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe**

The Sixty-third World Health Assembly,

PP1 Having considered the report on counterfeit medical products;<sup>1</sup>

PP2 Recalling resolution WHA41.16 on the rational use of drugs requesting the Director-General to initiate programmes for the prevention and detection of export, import and smuggling of falsely labelled, spurious, counterfeited or substandard pharmaceutical preparations;

PP3 Recalling resolution WHA47.13 on the rational use of drugs requesting the Director-General to support Member States in their efforts in combating the use of counterfeit drugs;

PP4 Recalling resolution WHA52.19 on the revised drug strategy and in particular the request to the Director-General to develop and disseminate uniform guidelines on the regulatory control, export, import and transit conditions of pharmaceutical products; and to develop standards of practice for entities involved in international trade in pharmaceuticals and pharmaceutical starting materials;

PP5 Recalling the continuous and repeated request from drug regulatory authorities of Member States that met in the framework of the International Conferences of Drug Regulatory Authorities to WHO to assist Member States to adopt measures to combat counterfeit medicines;

PP6 Concerned about the situation in which counterfeit medical products continue to move in international commerce, representing a major threat to public health, especially in the poorer areas of developing countries where regulatory capacities and law enforcement authorities are weak, and in which counterfeit medical products pose a challenge to the credibility and effectiveness of health systems;

PP7 Recognizing that the primary focus of combating the manufacture, distribution and use of counterfeit medical products is the protection of public health and that the main victims of counterfeiters are patients and the general public;

PP8 Recognizing that combating counterfeit medical products is one specific aspect of assuring quality, safety and efficacy of medical products;

PP9 Recognizing the importance of ensuring that combating counterfeit medical products does not result in hindering the availability of legitimate generic medicines;

PP10 Recognizing the various initiatives and progress achieved since 1988 by specific WHO guidelines for combating counterfeit medical products, and improvement of guidelines on import procedures for pharmaceutical products, inspection of drug distribution channels and good distribution practices for pharmaceutical products;

PP11 Aware of the importance of ensuring effective collaboration among patients, health professionals, the private sector and government institutions to combat counterfeit medical products effectively;

PP12 Cognizant of the importance of ensuring international collaboration and exchange of information in order to combat counterfeit medical products effectively;

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<sup>1</sup> Document A63/23.

PP13 Noting with satisfaction that the Director-General has intensified activities aimed at strengthening international collaboration to combat counterfeit medical products and that WHO has a leading role in these activities;

PP14 Recognizing the contribution of all parties concerned to the fulfilment of their responsibilities in compliance with the components of resolutions WHA41.16, WHA47.13 and WHA52.19 that specifically focus on combating counterfeit medical products, and encouraging all parties to continue that action;

PP15 Inviting bilateral agencies, multilateral bodies inside and outside the United Nations system, and voluntary organizations to collaborate and to provide support to developing countries in setting up and carrying out programmes aimed at combating counterfeit medical products, and acknowledging the work of those countries that are already doing so;

PP16 Requesting governments, pharmaceutical manufacturers and other concerned parties to cooperate in the detection, investigation and prevention of the increasing incidence of counterfeited or other substandard medical products moving in international commerce;

PP17 Aware of the public health impact of counterfeit medicines in achieving Millennium Development Goal 8 as it relates to international collaboration, in particular Target 8.E on the availability and access to quality medicines,

1. URGES Member States:

- (1) to reaffirm their commitment to develop, implement and monitor national policies and to take all necessary measures in order to ensure access to medical products that meet regulatory standards;
- (2) to establish and enforce legislation and regulations that prevent counterfeit medical products from being manufactured, exported, imported or traded in international transactions as well as to regulate and monitor the supply and distribution systems;
- (3) to establish effective mechanisms of coordination and collaboration, including exchange of information among health, law enforcement and other relevant authorities in order to improve prevention, detection, investigation and prosecution of cases of counterfeit medical products;
- (4) to promote awareness among health professionals and consumers of the risks posed by the use of counterfeit medical products including those acquired through unauthorized outlets including Internet sites;

2. REQUESTS the Director-General:

- (1) to continue to address counterfeit medical products as an integral part, within the existing framework, of standard setting for quality, safety and efficacy;
- (2) to provide support to Member States in developing and implementing policies and programmes aimed at combating counterfeit medical products, including facilitating the exchange of information at the international level and the development of tools, guidelines, training and awareness initiatives, and methodology for evaluation and monitoring;
- (3) to continue the development and dissemination of independent and timely information on instances of counterfeit medical products;

(4) to cooperate with Member States, at their request, and with international organizations and other relevant parties in detecting, monitoring and analysing cases of counterfeit medical products and their impact on public health;

(5) to report to the Sixty-fifth World Health Assembly, through the Executive Board, both on progress achieved and problems encountered in the implementation of this resolution.

**Agenda item 11.3****A63/A/Conf.Paper No.7  
18 May 2010****Measures to ensure access to safe, efficacious,  
quality and affordable medical products****Draft resolution proposed by the delegations of India and Thailand**

The Sixty-third World Health Assembly,

PP1 Recalling the Constitution of WHO, which states that “the objective of WHO shall be the attainment by all peoples of the highest possible level of health”;

PP2 Recalling the principles of the Global strategy and plan of action on public health, innovation and intellectual property as adopted by the World Health Assembly in resolution WHA61.21;

PP3 Emphasizing the importance of ensuring access to affordable medicines, technologies and other health products among people in need while ensuring the quality, safety and efficacy of medical products<sup>1</sup> and promoting the rational use of medicines;

PP4 Concerned about reports of medical products with compromised quality, safety and efficacy, and stressing the need to ensure the availability of safe, efficacious, quality and affordable medical products;

PP5 Recognizing that falsely labelled or substandard medical products can have serious consequences for the health of the population;

PP6 Noting that the term and definition of “counterfeit” relates to infringement of intellectual property rights and should not be equated with medical products with compromised quality, safety and efficacy;

PP7 Noting that the definition in the Agreement on Trade-related Aspects of Intellectual Property Rights definition that “counterfeit trademark goods” shall mean any goods, including packaging, bearing without authorization a trademark which is identical to the trademark validly registered in respect of such goods, or which cannot be distinguished in its essential aspects from such

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

a trademark, and which thereby infringes the rights of the owner of the trademark in question under the law of the country of importation;<sup>1</sup>

PP8 Recognizing that issues of protection and enforcement of intellectual property rights are distinct from issues of quality, safety and efficacy of medical products;

PP9 Seriously concerned about numerous incidences of intellectual property enforcement measures that have resulted in unwarranted seizures of generic medicines, affecting timely access to efficacious affordable medical products for people in developing countries, including least-developed countries;

PP10 Recognizing that infringement of intellectual property rights is being confused with the issues of quality, safety and efficacy;

PP11 Recognizing that high prices of medical products result in inequitable access and facilitate proliferation of medical products with compromised quality, safety and efficacy;

PP12 Resolving to take immediate steps to promote the availability of affordable, quality, safe, and efficacious medical products;

PP13 Recognizing the need to promote measures to address quality, safety and efficacy of medical products that do not themselves become barriers to timely availability of affordable medical products and production of generic medical products;

PP14 Recognizing that the International Medical Products Anti-Counterfeiting Taskforce, or its Terms of Reference, has not been approved by any governing body of WHO and that there are conflicts of interest in its composition,

1. URGES Member States:

(1) to take measures to strengthen national drug regulatory authorities by enhancing their capacity to ensure for all, and particularly to vulnerable groups, access to safe, efficacious, quality and affordable medical products;

(2) to address the basic causes of the circulation of medicines with compromised safety, efficacy and quality such as weak regulatory capacity, unethical promotion of medicines, and high prices of medical products;

(3) to take measures to remove barriers to access to quality, safe, efficacious and affordable medical products;

(4) to ensure incorporation of public health safeguards, including as reaffirmed by the Doha Declaration on the TRIPS Agreement and Public Health, in their domestic intellectual property legislation;

(5) to implement trade, intellectual property and other policies without constraining policy space for health, including access to quality, safe, efficacious and affordable medical products and production of generic medical products;

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<sup>1</sup> Agreement on Trade-related Aspects of Intellectual Property Rights Article 51, footnote 14(a).

(6) to refrain from applying measures to enforce intellectual property rights, such as the seizure of medical products in transit, that result in creating barriers to legitimate trade of generic medicines and impeding access to medical products, particularly in developing countries;

(7) to promote close collaboration among the national drug regulatory authorities to share information inspection techniques and testing methods;

2. REQUESTS the Director-General:

(1) to provide support to Member States, upon request, in strengthening their national drug regulatory authorities with a focus on enhancing their capacity, technical knowledge, infrastructure, facilities, and promoting robust systems to ensure that medical products available in their jurisdiction are of quality, safe and efficacious;

(2) to provide support for the development of new techniques and test methods for the use of national drug regulatory authorities to ensure the quality, safety and efficacy of medical products;

(3) to replace WHO's involvement in the International Medical Products Anti-Counterfeiting Taskforce with an effective programme to address the issues of quality, safety and efficacy as detailed in this resolution and ensure that the new programme avoids conflicts of interests, is evidence-based, transparent and Member-driven;

(4) to advocate that WHO does not get involved with infringement of intellectual property rights and other measures that could potentially undermine availability of quality, safe, efficacious and affordable medical products and production of generic medical products;

(5) to create measures to ensure that intellectual property enforcement does not inhibit access to affordable medical products;

(6) to report on implementation of this resolution to the Sixty-fourth World Health Assembly and subsequently biennially, through the Executive Board.

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## **ANNEXES**





## ANNEX 1

### **Policy on WHO engagement with global health partnerships and hosting arrangements<sup>1</sup>**

[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, UNITAID, 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

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<sup>1</sup> 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 framework<sup>1</sup> 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

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<sup>1</sup> 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.<sup>1</sup>

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

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<sup>1</sup> 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.

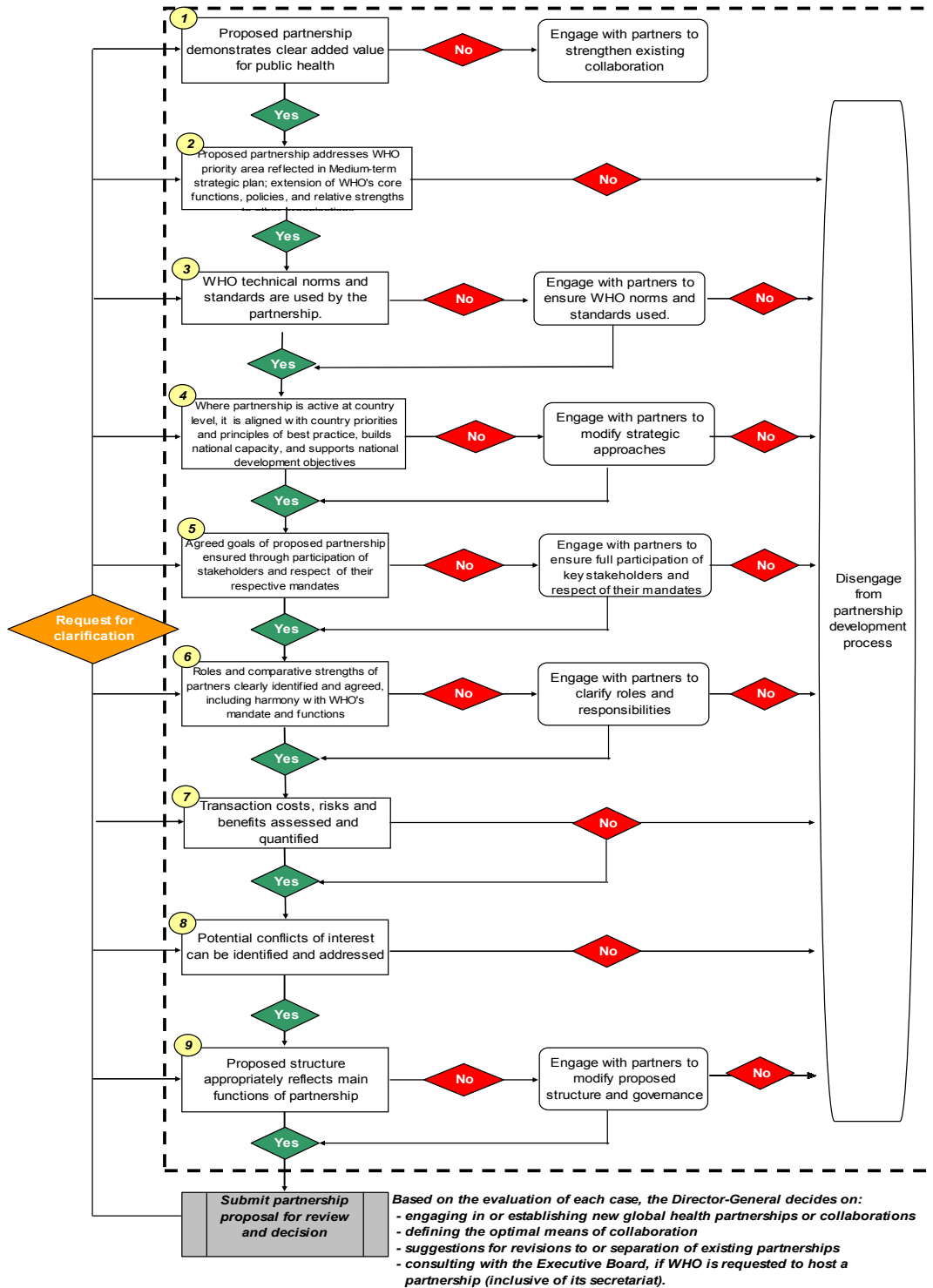
and for revision of WHO's hosting arrangement; (3) integrating the partnership into WHO with clear specifications for ensuring broad and inclusive collaboration with partners; or (4) separating the partnership from WHO.

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 Organization<sup>1</sup>**

[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.

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<sup>1</sup> See resolution WHA63.11.



## ANNEX 3

### Global strategy to reduce the harmful use of alcohol<sup>1</sup>

[A63/13 – 25 March 2010]

#### Setting the scene

1. The harmful use of alcohol<sup>2</sup> 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 alcohol<sup>3</sup> 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.<sup>4</sup> 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

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<sup>1</sup> See resolution WHA63.13.

<sup>2</sup> 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.

<sup>3</sup> 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.

<sup>4</sup> 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.<sup>1</sup> Although much of the evidence comes from high-income countries, the results of meta-analyses and reviews of the available evidence<sup>2</sup> 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

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

<sup>2</sup> 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.<sup>1</sup>

### **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

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<sup>1</sup> 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 alcohol<sup>1</sup>
- (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;

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<sup>1</sup> “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. Marketing<sup>1</sup> 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;

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<sup>1</sup> 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)

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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.

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## ANNEX 4

### **Set of recommendations on the marketing of foods and non-alcoholic beverages to children<sup>1</sup>**

[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

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<sup>1</sup> 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 food<sup>1</sup> marketing<sup>2</sup> to children are widespread across the world.<sup>3</sup> Most of this marketing is for foods with a high content of fat, sugar or

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

<sup>2</sup> “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.

<sup>3</sup> 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](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](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](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.<sup>1</sup>

**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.

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<sup>1</sup> 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.

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## ANNEX 5

### WHO Global Code of Practice on the International Recruitment of Health Personnel<sup>1</sup>

#### *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;

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<sup>1</sup> 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.



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***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.

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## ANNEX 6

### Interventions to prevent or treat birth defects<sup>1</sup>

[A63/10 – 1 April 2010]

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

<sup>1</sup> See resolution WHA63.17.

## ANNEX 7<sup>1</sup>

### 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.

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<sup>1</sup> 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 problem<sup>1</sup>
- 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.

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<sup>1</sup> 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.<sup>1</sup> 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.<sup>2</sup>

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.

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

<sup>2</sup> "Overview of Research at WHO 2006/07", available online at [http://www.who.int/rpc/research\\_strategy/en/index.html](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><b>Biennial report to the Health Assembly</b>, indicating:</p> <ul style="list-style-type: none"> <li>– progress in implementing and evaluating the research strategy and related expenditures (Organization goal)<sup>1</sup></li> <li>– global progress in strengthening national health research systems as measured using standardized indicators at the country level (priorities goal)</li> <li>– the adaptation/adoption of norms and standards by Member States and the results of audits examining adherence to them (standards goal)</li> </ul>
<p><b>Biennial report to the Director-General</b>, indicating:</p> <ul style="list-style-type: none"> <li>– the processes, coverage and impact of: <ul style="list-style-type: none"> <li>• WHO's revised recruitment procedures and incentives, and the Organization's training programme on research and research use (Organization goal)</li> <li>• WHO's ethical review committees (standards goal)</li> <li>• WHO's guideline review committee (standards goal)</li> <li>• WHO's programme review committee (Organization goal)</li> </ul> </li> </ul>

<sup>1</sup> The goal to which the output is most closely related is indicated in brackets.

- 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)

#### **Norms and standards**

- 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)

#### **Public reports and resources**

- 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.<sup>1</sup>

**Table 2. List of indicators**

<p><b>Impact</b></p> <ul style="list-style-type: none"> <li>– 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)</li> <li>– 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)</li> </ul>
<p><b>Outcomes</b></p> <ul style="list-style-type: none"> <li>– Percentage, within a random sample, of WHO's guidelines that are aligned with the best available research evidence (Organization goal)</li> <li>– 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)</li> </ul>
<p><b>Outputs</b></p> <ul style="list-style-type: none"> <li>– Biennial report on progress in strengthening national health research systems submitted to the Health Assembly (capacity goal)</li> <li>– Norms and standards for research published (standards goal)</li> </ul>
<p><b>Inputs/activities</b></p> <ul style="list-style-type: none"> <li>– 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)</li> <li>– Percentage of Member States whose priority-setting processes have been drawn on to inform priorities in research for health (priorities goal)</li> </ul>

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.

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

## ANNEX 8<sup>1</sup>

### 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,<sup>2</sup> 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

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<sup>1</sup> See resolution WHA63.22.

<sup>2</sup> 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**

<p>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.</p>
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#### **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.

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**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.

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