RESOLUTIONS

WHA66.1 Twelfth General Programme of Work, 2014–2019

The Sixty-sixth World Health Assembly,

Having considered the draft twelfth general programme of work, 2014–2019,[1]

1. APPROVES the Twelfth General Programme of Work, 2014–2019;

2. REQUESTS the Director-General:

(1) to use the Twelfth General Programme of Work as the basis for strategic planning, monitoring and evaluation of WHO's work during the period 2014–2019;

(2) to take into consideration the changing state of global health in implementing the general programme of work, in consultation with Member States;

(3) to report, through the Executive Board, to the Seventy-third World Health Assembly on progress made during the period of the Twelfth General Programme of Work, 2014–2019.

(Eighth plenary meeting, 24 May 2013 –
Committee A, first report)

WHA66.2 Programme budget 2014–2015

The Sixty-sixth World Health Assembly,

Having considered the Proposed programme budget 2014–2015,[2]

1. APPROVES the programme of work, as outlined in the Proposed programme budget 2014–2015;

2. APPROVES the budget for the financial period 2014–2015, under all sources of funds, namely, assessed and voluntary contributions of US$ 3977 million;

3. ALLOCATES the budget for the financial period 2014–2015 to the following six categories:

(1) Communicable diseases US$ 841 million;

(2) Noncommunicable diseases US$ 318 million;

(3) Promoting health through the life course US$ 388 million;

[1] Document A66/6.

[2] Document A66/7.

(4) Health systems US$ 531 million;

(5) Preparedness, surveillance and response US$ 287 million;

(6) Enabling functions/corporate services US$ 684 million as well as the emergencies component of the budget US$ 928 million;

4. RESOLVES that the budget will be financed as follows:

(1) by net assessments on Member States adjusted for estimated Member State non-assessed income for a total of US$ 929 million;

(2) from voluntary contributions for a total of US$ 3048 million;

5. FURTHER RESOLVES that the gross amount of the assessed contribution for each Member State shall be reduced by the sum standing to their credit in the Tax Equalization Fund; that reduction shall be adjusted in the case of those Members that require staff members to pay income taxes on their WHO emoluments, taxes which the Organization reimburses to said staff members; the amount of such tax reimbursements is estimated at US$ 29.6 million, resulting in a total assessment on Members of US$ 958.6 million;

6. DECIDES that the Working Capital Fund shall be maintained at its existing level of US$ 31 million;

7. AUTHORIZES the Director-General to use the assessed contributions together with the voluntary contributions, subject to the availability of resources, to finance the budget as allocated in paragraph 3, up to the amounts approved;

8. FURTHER AUTHORIZES the Director-General, where necessary, to make budget transfers among the six categories provided in paragraph 3 above, up to an amount not exceeding 5% of the amount allocated to the category from which the transfer is made; the expenditure resulting from any such transfers being reported in the financial reports for the financial period 2014–2015;

9. FURTHER AUTHORIZES the Director-General, where necessary, to incur expenditures in the emergencies component of the budget beyond the amount allocated for this component, subject to availability of resources, and requests the Director-General to report to the governing bodies on availability of resources and expenditures in this segment;

10. REQUESTS the Director-General to submit regular reports on the financing and implementation of the budget and on the outcome of the financing dialogue, the strategic allocation of flexible funding and the results of the coordinated resource mobilization strategy, through the Executive Board and its Programme, Budget and Administration Committee, to the World Health Assembly.

(Eighth plenary meeting, 24 May 2013 –
Committee A, first report)

WHA66.3 Amendments to the Financial Regulations and Financial Rules

The Sixty-sixth World Health Assembly,

Having considered the reports on amendments to the Financial Regulations and Financial Rules,[1]

1. ADOPTS the amendments to the Financial Regulations,[2] to be effective as from 1 January 2014;

2. NOTES that the amendments to the Financial Rules were to be confirmed by the Executive Board at its 133rd session, to be effective at the same time as the amendments to the Financial Regulations adopted in paragraph 1;

3. AUTHORIZES the Director-General to number the revised Financial Regulations and Financial Rules appropriately.

(Eighth plenary meeting, 24 May 2013 –
Committee A, first report)

WHA66.4 Towards universal eye health: a global action plan 2014–2019[3]

The Sixty-sixth World Health Assembly,

Having considered the report and draft global action plan 2014–2019 on universal eye health;[4]

Recalling resolutions WHA56.26 on elimination of avoidable blindness and WHA62.1 and WHA59.25 on prevention of avoidable blindness and visual impairment;

Recognizing that the global action plan 2014–2019 on universal eye health builds upon the action plan for the prevention of avoidable blindness and visual impairment for the period 2009–2013;

Recognizing that globally, 80% of all visual impairment can be prevented or cured and that about 90% of the world's visually impaired live in developing countries;

Recognizing the linkages between some areas of the global action plan 2014–2019 on universal eye health and efforts to address noncommunicable diseases and neglected tropical diseases,

1. ENDORSES the global action plan 2014–2019 on universal eye health;[5]

2. URGES Member States:

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[1] Documents A66/33 and A66/57.

[2] Annex 1.

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

[4] Document A66/11.

[5] Annex 2.

(1) to strengthen national efforts to prevent avoidable visual impairment including blindness through, inter alia, better integration of eye health into national health plans and health service delivery, as appropriate;

(2) to implement the proposed actions in the global action plan 2014–2019 on universal eye health in accordance with national priorities, including universal and equitable access to services;

(3) to continue to implement the actions agreed by the World Health Assembly in resolution WHA62.1 on prevention of blindness and visual impairment and the action plan for the prevention of blindness and visual impairment for the period 2009–2013;

(4) to continue to support the work of the Secretariat to implement the current action plan to the end of 2013;

(5) to consider the programme and budget implications related to implementation of this resolution within the context of the broader programme budget;

3. REQUESTS the Director-General:

(1) to provide technical support to Member States for the implementation of the proposed actions in the global action plan 2014–2019 on universal eye health in accordance with national priorities;

(2) to further develop the global action plan 2014–2019 on universal eye health, in particular with regard to the inclusion of universal and equitable access to services;

(3) to continue to give priority to the prevention of avoidable visual impairment, including blindness, and to consider allocating resources for the implementation of the global action plan 2014–2019 on universal eye health;

(4) to report, through the Executive Board, to the Seventieth World Health Assembly in 2017, and the Seventy-third World Health Assembly in 2020, on progress in implementing the action plan.

(Eighth plenary meeting, 24 May 2013 –
Committee A, second report)

WHA66.5 Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan[1]

The Sixty-sixth World Health Assembly,

Mindful of the basic principle established in the Constitution of the World Health Organization, 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 Palestinian territory and other Arab occupied territories;

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

Taking note of the report of the Secretariat on the health conditions in the occupied Palestinian territory, including east Jerusalem and in the occupied Syrian Golan;[1]

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;

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, medical staff and ambulances to have access to the Palestinian health institutions in occupied east Jerusalem;

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 Gaza 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,

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;

(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, medical staff and ambulances to the Palestinian health institutions in occupied east Jerusalem and abroad;

(5) improve the living and medical conditions of Palestinian detainees, particularly children, women and patients, and provide the detainees who are suffering from serious medical

[1] Document A66/28.

conditions worsening every day with the necessary medical treatment and facilitate the transit and entry of medicine and medical equipment to the occupied Palestinian territory;

(6) 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 term and long term, as identified in the relevant reports of the Director-General including her report 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, that is applicable to the occupied Palestinian territory including east Jerusalem;

(5) to call upon all international humanitarian and human rights organizations, 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 sector;

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 plan and other relevant health plans of the Palestinian Government and to create a suitable environment to implement these plans with a view to help establishing and developing the specialized and relevant institutions of the future state of Palestine;

4. EXPRESSES its deep appreciation to the Director-General for her efforts to provide the 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 services including capacity building programmes;

(2) to provide health-related technical assistance to the Syrian population in the occupied Syrian Golan;

(3) to continue providing the necessary technical assistance in order to meet the health needs of the Palestinian people, including prisoners and detainees, and the handicapped and injured;

(4) to provide support also to the Palestinian health sector in preparing for emergency situations;

(5) to support the development of the health system in the occupied Palestinian territory, including the development of human resources;

(6) to report on progress in the implementation of this resolution to the Sixty-seventh World Health Assembly.

(Eighth plenary meeting, 24 May 2013 –
Committee B, first report)

WHA66.6 Financial Report and audited financial statements for the period 1 January 2012–31 December 2012

The Sixty-sixth World Health Assembly,

Having examined the Financial Report and audited financial statements for the period 1 January 2012–31 December 2012;[1]

Having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-sixth World Health Assembly,[2]

ACCEPTS the Director-General's Financial Report and audited financial statements for the period 1 January 2012–31 December 2012.

(Eighth plenary meeting, 24 May 2013 –
Committee B, first report)

[1] Document A66/29.

[2] Document A66/54.

WHA66.7 Implementation of the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children[1]

The Sixty-sixth World Health Assembly,

Having considered the report on follow-up actions to recommendations of the high-level commissions convened to advance women's and children's health;[2]

Recalling resolution WHA63.15 on monitoring of the achievement of the health-related Millennium Development Goals and resolution WHA65.7 on implementation of the recommendations of the United Nations Commission on Information and Accountability for Women's and Children's Health;

Recalling also that the United Nations Secretary-General called upon the global community through the Global Strategy for Women's and Children's Health to work together to save 16 million lives by 2015;

Acknowledging the pledges and commitments made by a large number of Member States and partners to the United Nations Secretary-General's Global Strategy for Women's and Children's Health;

Recognizing that millions of women and children die needlessly every year from conditions that are easily prevented by the use of existing, inexpensive medical commodities;

Recognizing also the need urgently to address and overcome the barriers that prevent women and children from accessing and using appropriate commodities;

Welcoming the report of the United Nations Commission on Life-Saving Commodities for Women and Children, which estimates that six million lives can be saved within five years by improving access to 13 specific, overlooked commodities and related products (see Annex);

Welcoming also the actions recommended by the United Nations Commission on Life-Saving Commodities for Women and Children and the implementation plan to deliver the actions;

Acknowledging that the actions recommended by the United Nations Commission on Life-Saving Commodities for Women and Children's Health will also increase access to a broader set of commodities;

Acknowledging also the need to promote, establish or support and strengthen the health services needed by women and children from before pregnancy to delivery, during the immediate post-delivery period, and childhood;

Reaffirming the importance of facilitating technology transfer on mutually agreed terms between developed and developing countries as well as among developing countries, as appropriate;

Acknowledging the role of the independent Expert Review Group in reviewing the progress made in implementing the recommended actions,

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

[2] Document A66/14.

1. URGES Member States to put into practice, as appropriate, the implementation plan on life-saving commodities for women and children, including:

(1) improving the quality, supply and use of the 13 life-saving commodities and other essential commodities for reproductive, maternal, newborn and child health, under the supervision and guidance of health care professionals, where needed, and building upon information and communication technology best practices for making these improvements;

(2) developing plans to implement at scale appropriate interventions in order to increase demand for and utilization of health services, particularly among underserved populations;

(3) facilitating universal access for all members of society, in particular the poorest, to the 13 life-saving commodities as well as to other essential commodities for reproductive, maternal, newborn and child health;

(4) improving regulatory efficiency by harmonizing registration requirements and streamlining assessment processes, including granting priority to review of the life-saving commodities;

(5) implementing proven mechanisms and interventions to ensure that health care providers are knowledgeable about the latest national guidelines for maternal and child health;

2. REQUESTS the Director-General:

(1) to work with UNICEF, UNFPA, the World Bank, UNAIDS, UN Women, national, regional and international regulators, private sector actors and other partners in order to promote and assure the availability of safe, quality commodities;

(2) to work with and support Member States, as appropriate, in improving regulatory efficiency, standardizing and harmonizing registration requirements and streamlining assessment processes, including granting priority to review of the life-saving commodities;

(3) to provide support to the independent Expert Review Group on Information and Accountability for Women's and Children's Health in its work on assessing the progress made in the implementation of the United Nations Secretary-General's Global Strategy for Women's and Children's Health, as well as in the implementation of the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children;

(4) to report annually until 2015, through the Executive Board, to the World Health Assembly on progress achieved in the follow-up of the recommendations of the Commission on Life-Saving Commodities for Women and Children, in connection with the agenda item concerning promoting health through the life course.

ANNEX

Commodities by life stage[1]

Maternal health commodities	
1	**Oxytocin** – post partum haemorrhage (PPH)
2	**Misoprostol** – post-partum haemorrhage
3	**Magnesium sulfate** – eclampsia and severe pre-eclampsia
Newborn health commodities	
4	**Injectable antibiotics** – newborn sepsis
5	**Antenatal corticosteroids (ANCs)** – preterm respiratory distress syndrome
6	**Chlorhexidine** – newborn cord care
7	**Resuscitation devices** – newborn asphyxia
Child health commodities	
8	**Amoxicillin** – pneumonia
9	**Oral rehydration salts** – diarrhoea
10	**Zinc** – diarrhoea
Reproductive health commodities	
11	**Female condoms**
12	**Contraceptive implants** – family planning/contraception
13	**Emergency contraception** – family planning/contraception

(Ninth plenary meeting, 27 May 2013 –
Committee A, third report)

WHA66.8 Comprehensive mental health action plan 2013–2020[2]

The Sixty-sixth World Health Assembly,

Having considered the report by the Secretariat on the draft comprehensive mental health action plan 2013–2020, including the Annex,[3]

1. ADOPTS the comprehensive mental health action plan 2013–2020;[1]

[1] See United Nations Commission on Life-Saving Commodities for Women and Children, Commissioner's Report, September 2012, Table 1, page 7.

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

[3] Document A66/10 Rev.1.

2. URGES Member States to implement the proposed actions for Member States in the comprehensive mental health action plan 2013–2020 as adapted to national priorities and specific national circumstances;

3. INVITES international, regional and national partners to take note of the comprehensive mental health action plan 2013–2020;

4. REQUESTS the Director-General to implement the actions for the Secretariat in the comprehensive mental health action plan 2013–2020 and to submit reports on the progress achieved in implementing the action plan, through the Executive Board, to the Sixty-eighth, Seventy-first and Seventy-fourth World Health Assemblies.

(Ninth plenary meeting, 27 May 2013 –
Committee A, fourth report)

WHA66.9 Disability[2]

The Sixty-sixth World Health Assembly,

Having considered the report on disability;[3]

Recalling resolution WHA58.23 on disability, including prevention, management and rehabilitation;

Recalling also the Convention on the Rights of Persons with Disabilities, signed by 155 countries and regional integration organizations and now ratified by 127, which highlights that disability is both a human rights issue and a development issue and, for States Parties, recommends that national policies and international development programmes are inclusive of and accessible to persons with disabilities;

Recalling further United Nations General Assembly resolutions calling for the mainstreaming of disability in the development agenda (resolution 64/131 on realizing the Millennium Development Goals for persons with disabilities, resolution 65/186 on realizing the Millennium Development Goals for persons with disabilities towards 2015 and beyond, and resolution 66/229 on the Convention on the Rights of Persons with Disabilities and the Optional Protocol thereto); resolution 66/288 endorsing the outcome document of the United Nations Conference on Sustainable Development; and resolution 66/124 deciding to convene a High-level Meeting of the General Assembly on the realization of the Millennium Development Goals and other internationally agreed development goals for persons with disabilities;

Recognizing existing national and regional efforts to facilitate the enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity;

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[1] Annex 3.

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

[3] Document A66/12.

Welcoming the first *World report on disability*,[1] which is based on the best available scientific evidence and which shows that many of the barriers people with disabilities face are avoidable and that the disadvantage associated with disability can be overcome;

Noting that an estimated 1000 million people live with disabilities; that this number is set to increase as populations age, as the prevalence of chronic health conditions rises, and in response to trends in environmental and other factors; that disability disproportionately affects vulnerable populations, notably women, older people and poor people; that low-income countries have a higher prevalence of disability than high-income countries; and that people with disabilities, particularly those in developing countries, experience poorer health than people without disabilities, higher rates of poverty, lower rates of educational participation and employment, increased dependency and restricted participation, and higher rates of violence and abuse than non-disabled people;

Further recalling that, according to the Convention on the Rights of Persons with Disabilities, persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments, which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others;

Recognizing the responsibility of Member States to take appropriate measures to ensure equal access to health services and care for persons with disabilities ideally through universal health coverage;

Recognizing also that people with disabilities have the same need for general health care as non-disabled people, yet have been shown to receive poorer treatment from health care systems than non-disabled people;

Recognizing further the important role that formal and informal caregivers play in supporting persons with disabilities and that, although informal caregivers cannot replace the role of the national and local authorities, they need particular attention from the authorities to help them with their tasks, and noting that both formal and informal caregivers' role is increasing in the context of the sustainability of health systems and the ageing of the population;

Acknowledging that providing universal access to health care and health services is an investment for society;

Also recognizing the extensive unmet needs for habilitation and rehabilitation services, which are vital to enable many people with a broad range of disabilities to participate in education, the labour market, and civic life, and, further, that measures to promote the health of people with disabilities and their inclusion in society through general and specialized health services are as important as measures to prevent people developing health conditions associated with disability;

Acknowledging that a comprehensive multisectoral approach is required to meet the multiple barriers faced by persons with disabilities and that mainstreaming disability in development is the most efficient and cost-effective way of meeting the needs of people with disabilities;

Welcoming the work of WHO's Task Force on Disability to raise awareness of disability as a cross-cutting issue in WHO's technical work, and in removing physical, information and policy barriers to the participation of people with disabilities in WHO's work,

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[1] World Health Organization, the World Bank. *World report on disability*. Geneva, World Health Organization, 2011.

1. ENDORSES the recommendations of the *World report on disability*, which offer strategies for the implementation of the Convention on the Rights of Persons with Disabilities;

2. URGES Member States:[1]

(1) to implement as States Parties the Convention on the Rights of Persons with Disabilities;

(2) to develop, as appropriate, plans of action, in close consultation with and active involvement of persons with disabilities, including children with disabilities, through their representative organizations, so that different sectors and different actors can coordinate effectively to remove barriers and enable persons with disabilities to enjoy their human rights and improve their quality of life;

(3) to establish and strengthen a monitoring and evaluation system with the goal of gathering appropriate sex- and age-disaggregated data, as well as other relevant information on disability, including prevalence, needs and unmet needs, direct and indirect costs, barriers and quality of life, using the International Classification of Functioning, Disability and Health, and effective programmes and good practices developed in different regions in order to ensure that data are nationally relevant and internationally comparable;

(4) to work to ensure that all mainstream health services are inclusive of persons with disabilities, an action that will necessitate, inter alia, adequate financing, social protection, comprehensive insurance coverage, accessible health care facilities, services and information, and training of health care professionals, in order to respect the human rights of persons with disabilities and to communicate with them effectively;

(5) to promote the receipt by informal caregivers of appropriate support in supplementing the services provided by health authorities;

(6) to promote habilitation and rehabilitation across the life course and for a wide range of health conditions through: early intervention; integrated and decentralized rehabilitation services, including mental health services; improved provision of wheelchairs, hearing aids, low vision devices and other assistive technologies; and training to ensure that there is a sufficient supply of rehabilitation professionals to enable people with disabilities to achieve their potential and have the same opportunities to participate fully in society;

(7) to promote and strengthen integrated community-based support and services as a multisectoral strategy that empowers all persons with disabilities to access, benefit from, and participate fully in inclusive education, employment, and health and social services;

(8) to prevent discrimination in access to health care or health services in order to promote equality;

3. REQUESTS the Director-General:

(1) to provide technical support to Member States in implementing the recommendations of the *World report on disability*;

[1] And, where applicable, regional economic integration organizations.

(2) to provide support to Member States, intensifying collaboration with a broad range of stakeholders including organizations of the United Nations system, academia, the private sector and organizations for persons with disabilities, in the implementation of the Convention on the Rights of Persons with Disabilities, in particular Articles 16 (Freedom from exploitation, violence and abuse), 19 (Living independently and being included in the community), 20 (Personal mobility), 25 (Health), 26 (Habilitation and rehabilitation) and 31 (Statistics and data collection) across the global health agenda;

(3) to ensure that the health needs of children and adults with disabilities are included in WHO's technical work on, inter alia, child and adolescent health, sexual, reproductive and maternal health, long-term care for older people, care and treatment of noncommunicable conditions, work on HIV/AIDS and other communicable diseases, emergency risk management, and health system strengthening;

(4) to ensure also that the WHO Secretariat itself is inclusive of people with disabilities, whether they be visitors, collaborators or employees, by continuing to create accessible premises and information, providing reasonable accommodation and by ensuring that people with disabilities are consulted closely and involved actively through their representative organizations wherever necessary and appropriate;

(5) to support, and participate in, the High-level Meeting of the United Nations General Assembly on the Realization of the Millennium Development Goals and Other Internationally Agreed Development Goals for Persons with Disabilities, as well as efforts to include disability in the post-2015 development agenda by drawing attention to disability data, support and services, and to health and rehabilitation needs and related responses;

(6) to prepare, in consultation with other organizations of the United Nations system and Member States[1] and within existing resources, a comprehensive WHO action plan with measurable outcomes, based on the evidence in the *World report on disability*, in line with the Convention on the Rights of Persons with Disabilities and the report of the High-level Meeting of the United Nations General Assembly on Disability, "The way forward: a disability-inclusive development agenda towards 2015 and beyond", for consideration, through the Executive Board, by the Sixty-seventh World Health Assembly.

(Ninth plenary meeting, 27 May 2013 –
Committee A, fourth report)

WHA66.10 Follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases[2]

The Sixty-sixth World Health Assembly,

Having considered the reports to the Sixty-sixth World Health Assembly on noncommunicable diseases;[3]

[1] And, where applicable, regional economic integration organizations.

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

[3] Documents A66/8, A66/9 and A66/9 Corr.1.

Recalling the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases,[1] which acknowledges that the global burden and threat of noncommunicable diseases constitutes one of the major challenges for development in the twenty-first century and which also requests the development of a comprehensive global monitoring framework, including a set of indicators, calls for recommendations on a set of voluntary global targets, and requests options for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases through effective partnership;

Welcoming the outcome document of the United Nations Conference on Sustainable Development (Rio de Janeiro, 20–22 June 2012), entitled "The future we want",[2] which commits to strengthen health systems towards the provision of equitable, universal health coverage and promote affordable access to prevention, treatment, care and support related to noncommunicable diseases, especially cancer, cardiovascular diseases, chronic respiratory diseases and diabetes, and commits to establish or strengthen multisectoral national policies for the prevention and control of noncommunicable diseases;

Taking note with appreciation of all the regional initiatives undertaken on the prevention and control of noncommunicable diseases, including the Declaration of the Heads of State and Government of the Caribbean Community entitled "Uniting to stop the epidemic of chronic noncommunicable diseases", adopted in September 2007, the Libreville Declaration on Health and Environment in Africa, adopted in August 2008, the statement of the Commonwealth Heads of Government on action to combat noncommunicable diseases, adopted in November 2009, the declaration of commitment of the Fifth Summit of the Americas, adopted in June 2009, the Parma Declaration on Environment and Health, adopted by the Member States of the WHO European Region in March 2010, the Dubai Declaration on Diabetes and Chronic Noncommunicable Diseases in the Middle East and Northern Africa Region, adopted in December 2010, the European Charter on Counteracting Obesity, adopted in November 2006, the Aruba Call for Action on Obesity of June 2011, and the Honiara Communique on addressing noncommunicable disease challenges in the Pacific region, adopted in July 2011;

Acknowledging the Moscow Declaration adopted by the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control (Moscow, 28–29 April 2011), endorsed by the Sixty-fourth World Health Assembly (resolution WHA64.11), which requests the Director-General to develop, together with relevant United Nations agencies and entities, an implementation and follow-up plan for the outcomes of the Conference and the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases (New York, 19–20 September 2011) for submission to the Sixty-sixth World Health Assembly;

Acknowledging also the Rio Political Declaration on Social Determinants of Health adopted by the World Conference on Social Determinants of Health (Rio de Janeiro, 19–21 October 2011), endorsed by the Sixty-fifth World Health Assembly in resolution WHA65.8, which recognizes that health equity is a shared responsibility and requires the engagement of all sectors of government, all segments of society, and all members of the international community, in an "all-for-equity" and "health-for-all" global action;

Recalling resolution EB130.R7, which requests the Director-General to develop, in a consultative manner, a WHO global action plan for the prevention and control of noncommunicable

[1] United Nations General Assembly resolution 66/2.

[2] United Nations General Assembly resolution 66/288.

diseases for 2013–2020 and decision WHA65(8) and its historic decision to adopt a global target of a 25% reduction in premature mortality from noncommunicable diseases by 2025;

Reaffirming WHO's leading role as the primary specialized agency for health, including its roles and functions with regard to health policy in accordance with its mandate, and reaffirming its leadership and coordination role in promoting and monitoring global action against noncommunicable diseases in relation to the work of other relevant United Nations agencies, development banks and other regional and international organizations in addressing noncommunicable diseases in a coordinated manner;

Recognizing the primary role and responsibility of governments in responding to the challenges of noncommunicable diseases;

Recognizing also the important role of the international community and international cooperation in assisting Member States, particularly developing countries, in complementing national efforts to generate an effective response to noncommunicable diseases;

Stressing the importance of North–South, South–South and triangular cooperation in the prevention and control of noncommunicable diseases, to promote at the national, regional and international levels an enabling environment to facilitate healthy lifestyles and choices, bearing in mind that South–South cooperation is not a substitute for, but rather a complement to, North–South cooperation;

Noting that noncommunicable diseases are often associated with mental disorders and other conditions and that mental disorders often coexist with other medical and social factors as noted in resolution WHA65.4 and that, therefore, the implementation of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020 is expected to be implemented coherently and in close coordination with the WHO global mental health action plan 2013–2020 and other WHO action plans at all levels;

Welcoming the overarching principles and approaches of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020,[1] and calling for their application in the implementation of all actions to prevent and control noncommunicable diseases;

Recognizing that the United Nations Secretary-General, in collaboration with Member States, WHO and relevant funds, programmes and specialized agencies of the United Nations system is to present to the United Nations General Assembly at its sixty-eighth session a report on the progress achieved in realizing the commitments made in the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, in preparation for a comprehensive review and assessment in 2014 of the progress achieved in the prevention and control of noncommunicable diseases,

1. DECIDES:

(1) to endorse the global action plan for the prevention and control of noncommunicable diseases 2013–2020;[2]

[1] As detailed in Annex 4, paragraph 18.

[2] Annex 4.

(2) to adopt the comprehensive global monitoring framework for the prevention and control of noncommunicable diseases, including the set of 25 indicators[1] capable of application across regional and country settings to monitor trends and to assess progress made in the implementation of national strategies and plans on noncommunicable diseases;

(3) to adopt the set of nine voluntary global targets for achievement by 2025 for the prevention and control of noncommunicable diseases,[3] noting that the target related to a 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases concerns premature mortality from noncommunicable diseases between ages 30 and 70, in accordance with the corresponding indicator;

2. URGES Member States:[2]

(1) to continue to implement the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, strengthening national efforts to address the burden of noncommunicable diseases, and continuing to implement the Moscow Declaration;

(2) to implement, as appropriate, the action plan and to take the necessary steps to meet the objectives contained therein;

(3) to enhance the capacity, mechanisms and mandates, as appropriate, of relevant authorities in facilitating and ensuring action across government sectors;

(4) to accelerate implementation by Parties of the WHO Framework Convention on Tobacco Control, including through adopted technical guidelines; other countries to consider acceding to the Convention, as well as to give high priority to the implementation of the Global Strategy on Diet, Physical Activity and Health endorsed in resolution WHA57.17, the global strategy to reduce the harmful use of alcohol endorsed in resolution WHA63.13, and the recommendations on the marketing of foods and non-alcoholic beverages to children endorsed in resolution WHA63.14, as being integral to making progress towards the voluntary global targets and realizing the commitments made in the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases;

(5) to promote, establish, support and strengthen engagement or collaborative partnerships, as appropriate, including with non-health and non-State actors, such as civil society and the private sector, at the national, subnational and/or local levels for the prevention and control of noncommunicable diseases, according to country circumstances, with a broad multisectoral approach, while safeguarding public health interests from undue influence by any form of real, perceived or potential conflict of interest;

(6) to consider the development of national noncommunicable disease monitoring frameworks, with targets and indicators based on national situations, taking into consideration the comprehensive global monitoring framework, including the 25 indicators and a set of nine voluntary global targets, building on guidance provided by WHO, to focus on efforts to prevent and address the impacts of noncommunicable diseases, to support scaling up effective noncommunicable disease actions and policies, including technical and financial aspects, and to

[1] See Annex 4, Appendix 2.

[2] And, where applicable, regional economic integration organizations.

assess the progress made in the prevention and control of noncommunicable diseases and their risk factors and determinants;

(7) to establish and strengthen, as appropriate, a national surveillance and monitoring system to enable reporting including against the 25 indicators of the comprehensive global monitoring framework, the nine voluntary global targets, and any additional regional or national targets and indicators for noncommunicable diseases;

(8) to recommend that the United Nations Economic and Social Council, before the end of 2013, considers the proposal for a United Nations Task Force on Noncommunicable Diseases, which would coordinate the activities of the United Nations organizations in the implementation of the WHO global noncommunicable disease action plan, which would be convened and led by WHO and report to ECOSOC, incorporating the work of the United Nations Ad Hoc Interagency Task Force on Tobacco Control while ensuring that tobacco control continues to be duly addressed and prioritized in the new task force mandate;

(9) to support the work of the Secretariat to prevent and control noncommunicable diseases, in particular through funding relevant work included in the programme budgets;

(10) to continue to explore the provision of adequate, predictable and sustained resources, through domestic, bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanisms and to increase, as appropriate, resources for national programmes for prevention and control of noncommunicable diseases;

3. REQUESTS the Director-General:

(1) to submit the detailed and disaggregated information on resource requirements necessary to implement the actions for the Secretariat included in the global action plan for the prevention and control of noncommunicable diseases 2013–2020, including information on the financial implications of the establishment of a global coordination mechanism for the prevention and control of noncommunicable diseases, to the first financing dialogue convened by the Director-General and facilitated by the Chairman of the Programme, Budget and Administration Committee of the Executive Board, on the financing of the Programme budget 2014–2015, with a view to ensuring that all partners have clear information on the specific funding needs, available resources and funding shortfalls of the actions for the Secretariat included in the action plan at the project or activity level;

(2) to develop draft terms of reference for a global coordination mechanism, as outlined in paragraphs 14–15 of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020, aimed at facilitating engagement among Member States, United Nations funds, programmes and agencies, and other international partners and non-State actors, while safeguarding WHO and public health from undue influence by any form of real, perceived or potential conflicts of interest, without pre-empting the results of ongoing WHO discussions on engagement with non-State actors;

(3) to develop the draft terms of reference referred to in paragraph 5.2 through a formal Member States'[1] meeting in November 2013, preceded by consultations with:

(i) Member States,[1] including through regional committees;

[1] And, where applicable, regional economic integration organizations.

(ii) United Nations agencies, funds and programmes and other relevant intergovernmental organizations;

(iii) nongovernmental organizations and private sector entities, as appropriate, and other relevant stakeholders;

and to be submitted, through the Executive Board, to the Sixty-seventh World Health Assembly for approval;

(4) to develop, in consultation with Member States and other relevant partners, a limited set of action plan indicators to inform reporting on progress, which build on the work under way at regional and country levels, are based on feasibility, current availability of data, best available knowledge and evidence, are capable of application across the six objectives of the action plan, and minimize the reporting burden on Member States to assess progress made in 2016, 2018 and 2021 in the implementation of policy options for Member States, recommended actions for international partners, and actions for the Secretariat included in the action plan, and to submit the draft set of action plan indicators, through the Executive Board, to the Sixty-seventh World Health Assembly for approval;

(5) to work together with other United Nations funds, programmes and agencies to conclude the work, before the end of October 2013, on a division of tasks and responsibilities for United Nations funds, programmes and agencies and other international organizations;

(6) to provide technical support to Member States, as required, to support the implementation of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020;

(7) to provide technical support to Member States, as required, to establish or strengthen national surveillance and monitoring systems for noncommunicable diseases to support reporting under the global monitoring framework for noncommunicable diseases;

(8) to provide technical support to Member States, as required, to engage/cooperate with non-health government sectors and, in accordance with principles for engagement, with non-State actors,[1] in the prevention and control of noncommunicable diseases;

(9) to submit reports on progress made in implementing the action plan, through the Executive Board, to the Health Assembly in 2016, 2018 and 2021,[2] and reports on progress achieved in attaining the nine voluntary global targets in 2016, 2021 and 2026;

(10) to propose an update of Appendix 3 of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020, as appropriate, to be considered, through the Executive Board, by the World Health Assembly, in the light of new scientific evidence and to continue to update, as appropriate, Appendix 4 of the Annex.

(Ninth plenary meeting, 27 May 2013 –
Committee A, fifth report)

[1] Without prejudice to ongoing discussions on WHO engagement with non-State actors.

[2] The progress reports in 2018 and 2021 should include the outcomes of independent evaluation of the implementation of the global action plan conducted in 2017 and 2020.

WHA66.11 Health in the post-2015 development agenda

The Sixty-sixth World Health Assembly,

Having considered the report on health in the post-2015 development agenda,[1]

Reaffirming the Constitution of the World Health Organization, which states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Reaffirming also the principles of the United Nations Millennium Declaration adopted by the United Nations General Assembly in resolution 55/2, including human dignity, equality and equity, and stressing the need for their reflection in the post-2015 development agenda;

Recalling the Annex to United Nations General Assembly resolution 64/299 on "Keeping the promise: united to achieve the Millennium Development Goals", which requested the Secretary-General to report annually on progress in the implementation of the Millennium Development Goals until 2015 and to make recommendations in his annual reports, as appropriate, for further steps to advance the United Nations development agenda beyond 2015;

Recalling also United Nations General Assembly resolution 66/288 on "The future we want", which recognized health as a precondition for and an outcome and indicator of all three dimensions of sustainable development and which included, inter alia, the establishment of an open working group that will submit a proposal for sustainable development goals for consideration by the United Nations General Assembly;

Recognizing United Nations General Assembly resolution 67/81 on "Global health and foreign policy", which, inter alia, recommended that consideration be given to including universal health coverage in the discussion on the post-2015 development agenda in the context of global health challenges;

Noting the outcome of the Global Thematic Consultation on Health in the Post-2015 Development Agenda, which culminated in a high-level dialogue in Gaborone, Botswana in March 2013;

Further recalling the Rio Political Declaration on Social Determinants of Health endorsed by the Sixty-fifth World Health Assembly in resolution WHA65.8 in May 2012;

Acknowledging the many global, regional and national consultations on health in the post-2015 UN development agenda that are under way;

Concerned that although some countries have made good progress towards attaining some of the health-related Millennium Development Goals, many others are not on track to full attainment of some or all of the health-related Goals by 2015;

Appreciating the need to sustain current achievements and accelerate efforts in those countries where more rapid progress is needed towards achievement of the health-related Millennium Development Goals by 2015,

[1] Document A66/47.

1. URGES Member States:[1]

(1) to ensure that health is central to the post-2015 UN development agenda;

(2) to strengthen country ownership in articulating national plans and priorities and aligning efforts and resources towards the achievement of the current health-related Millennium Development Goals building towards sustainable progress on health outcomes;

(3) to engage actively in discussions on the post-2015 UN development agenda, respecting the processes established by the United Nations General Assembly;

(4) to honour their commitments towards agreed health targets and goals and to sustain and accelerate efforts towards the achievement of the health-related Millennium Development Goals;

(5) to accelerate international cooperation to support countries that may not achieve the health-related Millennium Development Goals by 2015;

2. REQUESTS the Director-General:

(1) to ensure that WHO consultations on health in the post-2015 UN development agenda are inclusive and open to all regions, subregions and Member States,[2] and that such discussions are adequately informed by other ongoing processes;

(2) to continue active engagement with ongoing discussions on the post-2015 UN development agenda, working with the United Nations Secretary-General to ensure the centrality of health in all relevant processes;

(3) to advocate for intensified mobilization of financial and technical resources, in the spirit of the Busan Declaration on development effectiveness, in order to support Member States in accelerating their attainment of the health-related Millennium Development Goals targets by 2015;

(4) to include the discussion of health in the post-2015 UN development agenda as an agenda item in the 2013 meetings of the WHO regional committees and to present a report on those discussions, through the Executive Board at its 134th session in January 2014, to the Sixty-seventh World Health Assembly.

(Ninth plenary meeting, 27 May 2013 –
Committee A, fifth report)

[1] And, where applicable, regional economic integration organizations.

[2] And, where applicable, regional economic integration organizations.

WHA66.12 Neglected tropical diseases[1]

The Sixty-sixth World Health Assembly,

Having considered the report on neglected tropical diseases,[2] and recalling the previous World Health Assembly resolutions listed therein;

Recognizing that increased national and international investments in prevention and control of neglected tropical diseases have succeeded in improving health and social well-being in many countries;

Recognizing also the importance of the Global Plan to Combat Neglected Tropical Diseases 2008–2015;

Noting WHO's road map to accelerate the work to overcome the global impact of neglected tropical diseases;[1]

Acknowledging the linkages between, and mutual supportiveness of, control and elimination of neglected tropical diseases and the global strategy and plan of action on public health, innovation and intellectual property;

Acknowledging also that expansion of activities to prevent and control neglected tropical diseases will need adequately resourced national programmes functioning within effective health, education and other sectors in order to provide for an uninterrupted supply and delivery of quality-assured commodities and services;

Realizing that current approaches to the prevention and control of neglected tropical diseases, when implemented in an integrated manner and across all relevant sectors, are highly effective and contribute to stronger health systems and the achievement of the health-related Millennium Development Goals, but that there are still many challenges;

Appreciating the generous contribution of pharmaceutical companies in donating sufficient quantities of quality-assured essential medicines for the prevention and treatment of neglected tropical diseases, while acknowledging the need to ensure their continuous availability and affordability;

Recognizing the contribution of bodies in the United Nations system, intergovernmental and nongovernmental organizations, academic institutions and civil society;

Recognizing also the diversity of neglected tropical diseases, their causative agents and relevant vectors and intermediate hosts, their epidemic potential (such as for dengue, Chagas disease, human rabies of canine origin and leishmaniasis), and their morbidity, mortality and associated stigmatization,

1. URGES Member States:

(1) to ensure continued country ownership of programmes for neglected tropical disease prevention, control, elimination and eradication;

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

[2] Document A66/20.

(2) to further strengthen the disease surveillance system especially on neglected tropical diseases targeted for eradication;

(3) to expand and implement, as appropriate, interventions against neglected tropical diseases in order to reach the targets agreed in the Global Plan to Combat Neglected Tropical Diseases 2008–2015, as set out in WHO's road map for accelerating work to overcome the global impact of neglected tropical diseases, and noting the London Declaration on Neglected Tropical Diseases, by;

(a) ensuring that resources match national requirements and flow in a sustainable manner as a result of thorough planning and costing of prevention and control activities and detailed analysis of associated expenditures;

(b) enabling improvement of the management of the supply chain, in particular through forecasting, timely procurement of quality-assured goods, improved stock-management systems, and facilitating importation and customs clearance;

(c) integrating neglected tropical diseases control programmes into primary health care services and vaccination campaigns, or into existing programmes where feasible, in order to achieve greater coverage and reduce operational costs;

(d) ensuring appropriate programme management and implementation through the development, sustenance and supervision of a cadre of skilled staff (including other sectors than health) at national, district and community levels;

(4) to advocate predictable, long-term, international financing for the control of neglected tropical diseases;

(5) to enhance and sustain national financial commitments, including resource mobilization from sectors other than health;

(6) to strengthen capacity for prevention and control of neglected tropical diseases, strengthening research, in order to accelerate implementation of the policies and strategies designed to achieve the targets set by the Health Assembly in various resolutions related to specific neglected tropical diseases as well as in the road map for accelerating work to overcome the global impact of neglected tropical diseases and the London Declaration on Neglected Tropical Diseases;

(7) to strengthen national capacity for monitoring and evaluation of the impact of interventions against neglected tropical diseases;

(8) to devise plans for achieving and maintaining universal access to and coverage with interventions against neglected tropical diseases, notably:

(a) to provide prompt diagnostic testing of all suspected cases of neglected tropical diseases and effective treatment with appropriate therapy of patients in both the public and private sectors at all levels of the health system including the community level;

(b) to implement and sustain coverage with preventive chemotherapy[1] of at least 75% of the populations in need, as a prerequisite for achieving goals of disease control or elimination;

(c) to improve coordination for reducing transmission and strengthening control of neglected tropical diseases, taking into account social determinants of health, through provision of safe drinking-water, basic sanitation, health promotion and education, vector control and veterinary public health, taking into consideration One Health;

2. CALLS upon WHO's international partners, including intergovernmental, international and nongovernmental organizations, financing bodies, academic and research institutions, civil society and the private sector:

(1) to support Member States, as appropriate:

(a) to provide sufficient and predictable funding to enable the targets for 2015 and 2020 to be met and efforts to control neglected tropical diseases to be sustained;

(b) to harmonize the provision of support to countries for implementing a national plan based on WHO-recommended policies and strategies and using commodities that meet international quality standards;

(c) to promote universal access to preventive chemotherapy, and diagnostics, case management, and vector control and other prevention measures, as well as effective surveillance systems;

(2) to encourage initiatives for the research and development of new diagnostics, medicines, vaccines, and pesticides and biocides, improved tools and technologies and other innovative instruments for vector control and infection prevention and to support operational research to increase the efficiency and cost–effectiveness of interventions, taking into account the global strategy and plan of action on public health, innovation and intellectual property;

(3) to collaborate with WHO in order to provide support to Member States in measuring progress towards, and in accomplishing, their goals of elimination and eradication of selected neglected tropical diseases;

3. REQUESTS the Director-General:

(1) to sustain WHO's leadership in the drive to overcome neglected tropical diseases;

(2) to support the development and updating of evidence-based norms, standards, policies, guidelines and strategies and research for prevention, control and elimination of neglected tropical diseases in order to chart a course for reaching the related targets set in resolutions of the Health Assembly;

(3) to monitor progress in achieving the targets for neglected tropical diseases set in WHO's road map for accelerating work to overcome the global impact of neglected tropical diseases,

[1] Preventive chemotherapy means large-scale preventive treatment against helminthiases and trachoma with safe, single-dose, quality-assured medicines.

and to provide support to Member States in their efforts to collect, validate and analyse data from national surveillance systems;

(4) to provide support to Member States to strengthen human resource capacity for prevention, diagnosis and control of neglected tropical diseases, including vector control and veterinary public health;

(5) to encourage and support initiatives to discover and obtain new diagnostic tools, medicines and vector control measures, and to support operational research to increase the efficacy and cost–effectiveness of interventions;

(6) to report, through the Executive Board, to the Sixty-eighth World Health Assembly on progress towards the elimination and eradication of targeted diseases.

(Ninth plenary meeting, 27 May 2013 –
Committee A, fifth report)

WHA66.13 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution

The Sixty-sixth World Health Assembly,

Having considered the reports on status of collection of assessed contributions, including Members in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution, and special arrangements for settlement of arrears;[1]

Noting that, at the time of opening of the Sixty-sixth World Health Assembly, the voting rights of Central African Republic, Comoros, Grenada, Guinea-Bissau and Somalia were suspended, such suspension to continue until the arrears of the Members concerned have been reduced, at the present or future Health Assemblies, to a level below the amount that would justify invoking Article 7 of the Constitution;

Noting that Afghanistan, Antigua and Barbuda, Bosnia and Herzegovina, Cameroon, Côte d'Ivoire, Jordan, Kyrgyzstan, Malawi and Sierra Leone were in arrears at the time of the opening of the Sixty-sixth World Health Assembly to such an extent that it was necessary for the Health Assembly to consider, in accordance with Article 7 of the Constitution, whether or not the voting privileges of those countries should be suspended – for Afghanistan and Kyrgyzstan at the opening of the Sixty-sixth World Health Assembly, and for the remaining eight Member States at the opening of the Sixty-seventh World Health Assembly,

DECIDES:

(1) that in accordance with the statement of principles set out in resolution WHA41.7 if, by the time of the opening of the Sixty-seventh World Health Assembly, Antigua and Barbuda, Bosnia and Herzegovina, Cameroon, Côte d'Ivoire, Jordan, Malawi, and Sierra Leone are still in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution, their voting privileges shall be suspended as from the said opening; and in

[1] Documents A66/30 and A66/55.

accordance with resolution WHA59.6 and resolution WHA61.8 if, by the time of the opening of the Sixty-sixth World Health Assembly, Afghanistan and Kyrgyzstan, respectively, are still in arrears in the payment of their rescheduled assessments, their voting privileges shall be suspended automatically;

(2) that any suspension that takes effect as set out in paragraph (1) above shall continue at the Sixty-seventh World Health Assembly and subsequent Health Assemblies until the arrears of Afghanistan, Antigua and Barbuda, Bosnia and Herzegovina, Cameroon, Côte d'Ivoire, Jordan, Kyrgyzstan, Malawi and Sierra Leone have been reduced to a level below the amount that would justify invoking Article 7 of the Constitution;

(3) that this decision shall be without prejudice to the right of any Member to request restoration of its voting privileges in accordance with Article 7 of the Constitution.

(Ninth plenary meeting, 27 May 2013 –
Committee B, second report)

WHA66.14 Special arrangements for settlement of arrears: Tajikistan

The Sixty-sixth World Health Assembly,

Having considered the report by the Secretariat on the status of collection of assessed contributions,[1] and the request of Tajikistan;[2]

Noting that Tajikistan has outstanding contributions of US$ 366 513;

Considering the request of Tajikistan to reschedule this balance over the period 2013 to 2022,

1. DECIDES to allow Tajikistan to retain its voting privileges at the Sixty-sixth World Health Assembly on the following conditions:

Tajikistan shall pay its outstanding arrears of assessed contributions, totalling US$ 366 513 over 10 years from 2013 to 2022, as set out below, in addition to payment of its annual assessment for the current year;

Year	US$
2013	36 651
2014	36 651
2015	36 651
2016	36 651
2017	36 651
2018	36 651
2019	36 651
2020	36 651

[1] Document A66/30.

[2] Document A66/45.

2021	36 651
2022	36 654
Total	**366 513**

2. FURTHER DECIDES that, in accordance with Article 7 of the Constitution of the World Health Organization, voting privileges shall be automatically suspended if Tajikistan does not meet the requirements laid down in paragraph 1 above;

3. REQUESTS the Director-General to report to the Sixty-seventh World Health Assembly on the prevailing situation;

4. FURTHER REQUESTS the Director-General to communicate this resolution to the Government of Tajikistan.

(Ninth plenary meeting, 27 May 2013 –
Committee B, second report)

WHA66.15 Scale of assessments for 2014–2015

The Sixty-sixth World Health Assembly,

Having considered the report on the scale of assessments for 2014–2015,[1]

ADOPTS the scale of assessments of Members and Associate Members for the biennium 2014–2015 as set out below.

Members and Associate Members	WHO scale for 2014–2015 %
Afghanistan	0.0050
Albania	0.0100
Algeria	0.1370
Andorra	0.0080
Angola	0.0100
Antigua and Barbuda	0.0020
Argentina	0.4320
Armenia	0.0070
Australia	2.0741
Austria	0.7981
Azerbaijan	0.0400
Bahamas	0.0170
Bahrain	0.0390
Bangladesh	0.0100
Barbados	0.0080
Belarus	0.0560
Belgium	0.9981
Belize	0.0010
Benin	0.0030
Bhutan	0.0010
Bolivia (Plurinational State of)	0.0090
Bosnia and Herzegovina	0.0170

[1] Document A66/31.

Members and Associate Members	WHO scale for 2014–2015 %
Botswana	0.0170
Brazil	2.9342
Brunei Darussalam	0.0260
Bulgaria	0.0470
Burkina Faso	0.0030
Burundi	0.0010
Cambodia	0.0040
Cameroon	0.0120
Canada	2.9842
Cape Verde	0.0010
Central African Republic	0.0010
Chad	0.0020
Chile	0.3340
China	5.1484
Colombia	0.2590
Comoros	0.0010
Congo	0.0050
Cook Islands	0.0010
Costa Rica	0.0380
Côte d'Ivoire	0.0110
Croatia	0.1260
Cuba	0.0690
Cyprus	0.0470
Czech Republic	0.3860
Democratic People's Republic of Korea	0.0060
Democratic Republic of the Congo	0.0030
Denmark	0.6750
Djibouti	0.0010
Dominica	0.0010
Dominican Republic	0.0450
Ecuador	0.0440
Egypt	0.1340
El Salvador	0.0160
Equatorial Guinea	0.0100
Eritrea	0.0010
Estonia	0.0400
Ethiopia	0.0100
Fiji	0.0030
Finland	0.5190
France	5.5935
Gabon	0.0200
Gambia	0.0010
Georgia	0.0070
Germany	7.1416
Ghana	0.0140
Greece	0.6380
Grenada	0.0010
Guatemala	0.0270
Guinea	0.0010
Guinea-Bissau	0.0010
Guyana	0.0010
Haiti	0.0030
Honduras	0.0080
Hungary	0.2660
Iceland	0.0270

Members and Associate Members	WHO scale for 2014–2015 %
India	0.6660
Indonesia	0.3460
Iran (Islamic Republic of)	0.3560
Iraq	0.0680
Ireland	0.4180
Israel	0.3960
Italy	4.4483
Jamaica	0.0110
Japan	10.8338
Jordan	0.0220
Kazakhstan	0.1210
Kenya	0.0130
Kiribati	0.0010
Kuwait	0.2730
Kyrgyzstan	0.0020
Lao People's Democratic Republic	0.0020
Latvia	0.0470
Lebanon	0.0420
Lesotho	0.0010
Liberia	0.0010
Libya	0.1420
Lithuania	0.0730
Luxembourg	0.0810
Madagascar	0.0030
Malawi	0.0020
Malaysia	0.2810
Maldives	0.0010
Mali	0.0040
Malta	0.0160
Marshall Islands	0.0010
Mauritania	0.0020
Mauritius	0.0130
Mexico	1.8421
Micronesia (Federated States of)	0.0010
Monaco	0.0120
Mongolia	0.0030
Montenegro	0.0050
Morocco	0.0620
Mozambique	0.0030
Myanmar	0.0100
Namibia	0.0100
Nauru	0.0010
Nepal	0.0060
Netherlands	1.6541
New Zealand	0.2530
Nicaragua	0.0030
Niger	0.0020
Nigeria	0.0900
Niue	0.0010
Norway	0.8511
Oman	0.1020
Pakistan	0.0850
Palau	0.0010
Panama	0.0260
Papua New Guinea	0.0040

Members and Associate Members	WHO scale for 2014–2015 %
Paraguay	0.0100
Peru	0.1170
Philippines	0.1540
Poland	0.9211
Portugal	0.4740
Puerto Rico	0.0010
Qatar	0.2090
Republic of Korea	1.9941
Republic of Moldova	0.0030
Romania	0.2260
Russian Federation	2.4382
Rwanda	0.0020
Saint Kitts and Nevis	0.0010
Saint Lucia	0.0010
Saint Vincent and the Grenadines	0.0010
Samoa	0.0010
San Marino	0.0030
Sao Tome and Principe	0.0010
Saudi Arabia	0.8641
Senegal	0.0060
Serbia	0.0400
Seychelles	0.0010
Sierra Leone	0.0010
Singapore	0.3840
Slovakia	0.1710
Slovenia	0.1000
Solomon Islands	0.0010
Somalia	0.0010
South Africa	0.3720
South Sudan	0.0040
Spain	2.9732
Sri Lanka	0.0250
Sudan	0.0100
Suriname	0.0040
Swaziland	0.0030
Sweden	0.9601
Switzerland	1.0471
Syrian Arab Republic	0.0360
Tajikistan	0.0030
Thailand	0.2390
The former Yugoslav Republic of Macedonia	0.0080
Timor-Leste	0.0020
Togo	0.0010
Tokelau	0.0010
Tonga	0.0010
Trinidad and Tobago	0.0440
Tunisia	0.0360
Turkey	1.3281
Turkmenistan	0.0190
Tuvalu	0.0010
Uganda	0.0060
Ukraine	0.0990
United Arab Emirates	0.5950
United Kingdom of Great Britain and Northern Ireland	5.1794
United Republic of Tanzania	0.0090

Members and Associate Members	WHO scale for 2014–2015 %
United States of America	22.0000
Uruguay	0.0520
Uzbekistan	0.0150
Vanuatu	0.0010
Venezuela (Bolivarian Republic of)	0.6270
Viet Nam	0.0420
Yemen	0.0100
Zambia	0.0060
Zimbabwe	0.0020
Total	**100.0000**

(Ninth plenary meeting, 27 May 2013 –
Committee B, second report)

WHA66.16 Foreign exchange risk management

The Sixty-sixth World Health Assembly,

Having considered the report on foreign exchange risk management;[1]

Recognizing the need for ensuring long-term matching between currencies of income and expense,

1. DECIDES:

(1) that the currency of assessed contributions will from 2014 be denominated half in United States dollars and half in Swiss francs, calculated at the time of the approval of the programme budget and of the amount of the programme budget to be financed from assessed contributions;

(2) that this measure will concern all Member States for whom the total amount of annual assessed contributions is US$ 200 000 or greater, with Member States whose total annual assessed contributions are less than US$ 200 000 continuing to be assessed solely in United States dollars;

2. DECIDES to amend Financial Regulation 6.6 to read as follows:

6.6 Where the total of annual assessed contributions for a Member is US$ 200 000 or greater, that Member's contributions shall be assessed half in United States dollars and half in Swiss francs. Where the total of annual assessed contributions for a Member is less than US$ 200 000, that Member's contributions shall be assessed in United States dollars only. The contributions shall be paid in either United States dollars, euros or Swiss francs, or such other currency or currencies as the Director-General shall determine.

3. FURTHER DECIDES that the foregoing change to the Financial Regulations of the World Health Organization shall take effect from the closure of the Sixty-sixth World Health Assembly.

[1] Document A66/32.

(Ninth plenary meeting, 27 May 2013 –
Committee B, second report)

WHA66.17 Report of the External Auditor

The Sixty-sixth World Health Assembly,

Having considered the report of the External Auditor on the financial operations of the World Health Organization for the financial year ended 31 December 2012 to the Sixty-sixth World Health Assembly;[1]

Having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-sixth World Health Assembly,[2]

ACCEPTS the report of the External Auditor to the Sixty-sixth World Health Assembly.

(Ninth plenary meeting, 27 May 2013 –
Committee B, second report)

WHA66.18 Follow-up of the report of the Working Group on the Election of the Director-General of the World Health Organization[3]

The Sixty-sixth World Health Assembly,

Having considered the report on the follow-up of the report of the Working Group on the Election of the Director-General of the World Health Organization,[4]

1. ADOPTS the Code of Conduct for the Election of the Director-General of the World Health Organization as set out in Annex 1 to this resolution;

2. ESTABLISHES a candidates' forum open to all Member States,[5] as a non-decision-making platform for candidates, as set out in Annex 2 to this resolution;

3. APPROVES the standard form for a curriculum vitae, as set out in Annex 3 to this resolution, which shall be used henceforth by Member States proposing persons for the post of Director-General as the sole document to be submitted;

4. DECIDES that the curriculum vitae of each candidate shall be limited to 3500 words and shall also be submitted in electronic format in order to enable the Chairman of the Executive Board to verify that this limit is not exceeded;

5. FURTHER DECIDES to amend Rules 70 and 108 of the Rules of Procedure of the World Health Assembly and to add a new Rule 70*bis*, as set out in Annex 4 to this resolution;

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[1] Document A66/34.

[2] Document A66/58.

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

[4] Document A66/41.

[5] And, where applicable, regional economic integration organizations.

6. REQUESTS the Director-General:

(1) to explore options for the use of electronic voting for the appointment of the Director-General, including the financial and electronic security implications thereof, and to report thereon, through the Executive Board, to the Sixty-seventh World Health Assembly;

(2) to consolidate a description of the overall process for the election of the Director-General in a single draft reference document with a view to submitting it, through the Executive Board, for the consideration of the Sixty-seventh World Health Assembly.

ANNEX 1

CODE OF CONDUCT FOR THE ELECTION OF THE DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION

In resolution WHA65.15 concerning the report of the Working Group of Member States on the Process and Methods of the Election of the Director-General of the World Health Organization, the World Health Assembly decided, inter alia, that "a code of conduct, in line with Recommendation 7 of the report of the Joint Inspection Unit "Selection and Conditions of Service of Executive Heads in the United Nations System Organizations", which candidates for the post of Director-General of the World Health Organization and Member States should undertake to observe and respect, will be developed by the Secretariat for consideration by the Sixty-sixth World Health Assembly through the Executive Board."

This code of conduct (the "code") aims at promoting an open, fair, equitable and transparent process for the election of the Director-General of the World Health Organization. In seeking to improve the overall process, the code addresses several areas, including the submission of proposals, the conduct of electoral campaigns by Member States and candidates, as well as funding and financial matters.

The code is a political understanding reached by the Member States of the World Health Organization. It recommends desirable behaviour by Member States and candidates with regard to the election of the Director-General in order to increase the fairness, credibility, openness and transparency of the process and thus its legitimacy as well as the legitimacy and acceptance of its outcome. As such, the code is not legally binding but Member States and candidates are expected to honour its contents.

A. General requirements

I. Basic principles

The whole election process as well as electoral campaign activities related to it should be guided by the following principles that further the legitimacy of the process and of its result:

due regard to the principle of equitable geographical representation,

fairness,

equity,

transparency,

good faith,

dignity, mutual respect and moderation,

non-discrimination, and

merit.

II. Authority of the Health Assembly and the Executive Board in accordance with their Rules of Procedure

1. Member States accept the authority of the Health Assembly and the Executive Board to conduct the election of the Director-General in accordance with their Rules of Procedure and relevant resolutions and decisions.

2. Member States that propose persons for the post of Director-General have the right to promote those candidatures. The same applies to candidates with regard to their own candidature. In the exercise of that right, Member States and candidates should abide by all rules governing the election of the Director-General contained in the Constitution of the World Health Organization, the Rules of Procedure of the World Health Assembly, and the Rules of Procedure of the Executive Board as well as in relevant resolutions and decisions.

III. Responsibilities

1. It is the responsibility of Member States and candidates for the post of Director-General of the World Health Organization to observe and respect this code.

2. Member States acknowledge that the process of election of the Director-General should be fair, open, transparent, equitable and based on the merits of the individual candidates. They should make this code publicly known and easily accessible.

3. The Secretariat will also promote awareness of the code in accordance with the provisions of the code.

B. Requirements for the different steps of the election process

I. Submission of proposals

When proposing the name of one or more persons for the post of Director-General, Member States should include in their proposal a statement to the effect that they and the persons proposed by them pledge to observe the provisions of the code. The Director-General will remind Member States accordingly when inviting Member States to propose persons for the post of Director-General in accordance with Rule 52 of the Rules of Procedure of the Executive Board.

II. Electoral campaign

1. This code applies to electoral campaign activities related to the election of the Director-General whenever they take place until the appointment by the Health Assembly.

2. All Member States and candidates should encourage and promote communication and cooperation among one another during the entire election process. Member States and candidates should act in good faith bearing in mind the shared objectives of promoting equity, openness, transparency and fairness throughout the election process.

3. All Member States and candidates should consider disclosing their campaign activities (for example, hosting of meetings, workshops and visits) and communicate them to the Secretariat. Information so disclosed will be posted on a dedicated page of the WHO web site.

4. Member States and candidates should refer to one another with respect; no Member State or candidate should at any time disrupt or impede the campaign activities of other candidates. Nor should any Member State or any candidate make any oral or written statement or other representation that could be deemed slanderous or libellous.

5. Member States and candidates should refrain from improperly influencing the election process, by, for example, granting or accepting financial or other benefits as a quid pro quo for the support of a candidate, or by promising such benefits.

6. Member States and candidates should not make promises or commitments in favour of, or accept instructions from, any person or entity, public or private, and should avoid any other similar action, when that could undermine, or be perceived as undermining, the integrity of the election process.

7. Member States proposing persons for the post of Director-General should consider disclosing grants or aid funding to other Member States during the previous two years in order to ensure full transparency and mutual confidence among Member States.

8. Member States that have proposed persons for the post of Director-General should facilitate meetings between their candidate and other Member States, if so requested. Wherever possible, meetings between candidates and Member States should be arranged on the occasion of conferences or other events involving different Member States rather than through bilateral visits.

9. Travel by candidates to Member States to promote their candidature should be limited in order to avoid excessive expenditure that could lead to inequality among Member States and candidates. In this connection, Member States and candidates should consider using as much as possible existing mechanisms (sessions of the regional committees, Executive Board and Health Assembly) for meetings and other promotional activities linked to the electoral campaign.

10. Candidates, whether internal or external, should not combine their official travel with campaigning activities. Electoral promotion or propaganda under the guise of technical meetings or similar events should be avoided.

11. After the Director-General has dispatched all proposals, curricula vitae and supporting information to Member States in accordance with Rule 52 of the Rules of Procedure of the Executive Board, the Secretariat will open on the WHO web site a password-protected forum for questions and answers, open to all Member States and candidates who request to participate in such a forum. The Secretariat will also post on the WHO web site information on all candidates who so request including their curricula vitae and other particulars of their qualifications and experience as received from Member States, as well as their contact information. The web site will also provide links to individual web sites of candidates upon request. Each candidate is responsible for setting up and financing his or her own web site.

12. The Secretariat will also post on WHO's web site, at the time referred to in the first paragraph of Rule 52 of the Rules of Procedure of the Executive Board, information on the election process and the applicable rules and decisions, as well as the text of this code.

III. Nomination and appointment

1. The nomination and appointment of the Director-General is conducted by the Executive Board and the Health Assembly, respectively, in accordance with their Rules of Procedure and relevant resolutions and decisions. As a matter of principle in order to preserve the serenity of the proceedings,

candidates should not attend those meetings even if they form part of the delegation of a Member State.

2. Member States should abide strictly by the Rules of Procedure of the Executive Board and of the World Health Assembly and other applicable resolutions and decisions and respect the integrity, legitimacy and dignity of the proceedings. As such, they should avoid behaviours and actions, both inside and outside the conference room where the nomination and appointment take place, that could be perceived as aiming at influencing its outcome.

3. Member States should respect the confidentiality of the proceedings and the secrecy of the votes. In particular, they should refrain from communicating or broadcasting the proceedings during the private meetings through electronic devices.

4. In view of the secret nature of the vote for the nomination and appointment of the Director-General, Member States should refrain from publicly announcing in advance their intention to vote for a particular candidate.

IV. Internal candidates

1. WHO staff members, including the Director-General in office, who are proposed for the post of Director-General, are subject to the obligations contained in the WHO Constitution, Staff Regulations and Staff Rules as well as to the guidance that may be issued from time to time by the Director-General.

2. WHO staff members who are proposed for the post of Director-General must observe the highest standard of ethical conduct and strive to avoid any appearance of impropriety. WHO staff members must clearly separate their WHO functions from their candidacy and avoid any overlap, or perception of overlap, between campaign activities and their work for WHO. They also have to avoid any perception of conflict of interest.

3. WHO staff members are subject to the authority of the Director-General, in accordance with the applicable regulations and rules, in case of allegations of breach of their duties with regard to their campaign activities.

4. The Health Assembly or the Executive Board may call upon the Director-General to apply Staff Rule 650 concerning special leave to staff members who have been proposed for the post of Director-General.

ANNEX 2

CANDIDATES' FORUM

Convening and conduct of the forum

1. The candidates' forum will be convened by the Secretariat at the request of the Executive Board as a self-standing event preceding the Board, and will be chaired by the Chairman of the Board, with the support of the Officers of the Executive Board. The Board will formally convene the candidates' forum and decide its date at the session preceding the session at which the nomination will take place.

Timing

2. The candidates' forum shall be held not later than two months in advance of the session of the Board session at which the nomination will take place.

Duration

3. The duration of the candidates' forum will be decided by the Officers of the Board depending on the number of candidates. Notwithstanding the foregoing, the maximum duration of the forum shall be three days.

Format

4. Each candidate shall make a presentation of up to 30 minutes, which will be followed by a questions and answer session so that the overall duration of each interview shall be 60 minutes. The order of the interviews shall be determined by lot. The forum shall decide, upon the proposal of the Chairman, on detailed arrangement for the interviews.

5. Member States and Associate Members participating in the candidates' forum will be invited to prepare questions for each candidate during the initial presentation. Questions to be asked to each candidate will be drawn by lot by the Chairman.

Participation

6. Participation in the candidates' forum will be limited to Member States[1] and Associate Members of the World Health Organization.

7. For those Member States or Associate Members which are not able to attend, the candidates' forum will be broadcast by the Secretariat through a password-protected web site.

Documentation

8. The curricula vitae of candidates and other supporting information provided in line with Rule 52 of the Rules of Procedure of the Board will be made available electronically to all Member States and Associate Members in the language versions provided on a password-protected web site.

[1] And, where applicable, regional economic integration organizations.

ANNEX 3

FORM FOR CURRICULUM VITAE

<table>
<tr><td>Family name (surname):

First/other names:</td><td>Attach recent photograph</td></tr>
<tr><td colspan="2">Gender:</td></tr>
<tr><td>Place and country of birth:</td><td>Date of birth (Day/Month/Year):</td></tr>
<tr><td colspan="2">Citizenship:</td></tr>
<tr><td colspan="2">If you have ever been found guilty of the violation of any law (except minor traffic violations) give full particulars:</td></tr>
<tr><td>Civil status:</td><td>Number of dependants:</td></tr>
</table>

Address to which correspondence should be sent:	Telephone: Mobile phone: Fax: E-mail:

Degrees/certificates obtained:

(Please indicate here the principal degrees/certificates obtained, with dates and names of institutions. Additional pages may be added.)

Knowledge of languages		Mother tongue	Speak	Read	Write
For languages other than mother tongue, enter the appropriate number from the code below to indicate the level of your language knowledge. If no knowledge, please leave blank. CODE: 1. Limited conversation, reading of newspapers, routine correspondence. 2. Engage freely in discussions, read and write more difficult material 3. Fluent (nearly) as in mother tongue	Arabic	☐	☐	☐	☐
	Chinese	☐	☐	☐	☐
	English	☐	☐	☐	☐
	French	☐	☐	☐	☐
	Spanish	☐	☐	☐	☐
	Russian	☐	☐	☐	☐
	Others (please specify)				

Positions held

Please indicate here the positions and work experience held during your professional career, with the corresponding dates, duties, achievements/accomplishments and responsibilities. Additional pages may be added.

Please state any other relevant facts that might help in the evaluation of your application. List your activities in civil, professional, public or international affairs.

Please list here a maximum of 10 publications - especially the main ones in the field of public health, with names of journals, books or reports in which they appeared. An additional page may be used for this purpose, if necessary. (Please feel free also to attach a complete list of all publications.) Do not attach the publications themselves.

Please list hobbies, sports, skills and any other relevant facts that might help in the evaluation of your application:

WRITTEN STATEMENT

1. Please evaluate how you meet each of the "Criteria for candidates for the post of the Director-General of the World Health Organization" (see attached sheet). In so doing, please make reference to specific elements of your curriculum vitae to support your evaluation. The criteria adopted by the World Health Assembly in resolution WHA65.15 are the following:

(1) a strong technical background in a health field, including experience in public health;

(2) exposure to and extensive experience in international health;

(3) demonstrable leadership skills and experience;

(4) excellent communication and advocacy skills;

(5) demonstrable competence in organizational management;

(6) sensitivity to cultural, social and political differences;

(7) strong commitment to the mission and objectives of WHO;

(8) good health condition required of all staff members of the Organization; and

(9) sufficient skill in at least one of the official working languages of the Executive Board and the Health Assembly.

2. Please state your vision of priorities and strategies for the World Health Organization

ANNEX 4

RULES OF PROCEDURE OF THE WORLD HEALTH ASSEMBLY

Rule 70

Decisions by the Health Assembly on important questions shall be made by a two-thirds majority of the Members present and voting. These questions shall include: the adoption of conventions or agreements; the approval of agreements bringing the Organization into relation with the United Nations and with intergovernmental organizations and agencies in accordance with Articles 69, 70 and 72 of the Constitution; amendments to the Constitution; decisions on the amount of the effective working budget; and decisions to suspend the voting privileges and services of a Member under Article 7 of the Constitution.

Rule 70bis

The Director-General of the World Health Organization shall be elected by a clear and strong majority of members present and voting as set forth in Rule 108 of these Rules of Procedure.

Rule 108

The Health Assembly shall consider the Board's nomination at a private meeting and shall come to a decision by secret ballot.

1. If the Board nominates three persons, the following procedure shall apply:

(a) If in the first ballot a candidate obtains a two-thirds majority or more of the Members present and voting, this will be considered a clear and strong majority and he or she will be appointed Director-General. If no candidate obtains the required majority, the candidate having received the least number of votes shall be eliminated. If two candidates tie for the least number of votes, a separate ballot shall be held between them and the candidate receiving the least number of votes shall be eliminated.

(b) In the subsequent ballot, a candidate will be appointed Director-General if he or she obtains a two-thirds majority or more of the Members present and voting which will be considered a clear and strong majority.

(c) If no candidate receives the majority indicated in subparagraph (b), a candidate will be appointed Director-General if he or she receives in the subsequent ballot a majority of the Member States of the World Health Organization or more, which will be considered a clear and strong majority.

(d) If no candidate receives the majority indicated in subparagraph (c), a candidate will be appointed Director-General if he or she receives in the subsequent ballot a majority or more of the Members present and voting, which will be considered a clear and strong majority.

2. If the Board nominates two persons, the following procedure shall apply:

(a) a candidate will be appointed Director-General if he or she obtains a two-thirds majority or more of the Members present and voting, which will be considered a clear and strong majority.

(b) If no candidate receives the majority indicated in subparagraph (a), a candidate will be appointed Director-General if he or she receives in the subsequent ballot a majority of the Member States of the World Health Organization or more, which will be considered a clear and strong majority.

(c) If no candidate receives the majority indicated in subparagraph (b), a candidate will be appointed Director-General if he or she receives in the subsequent ballot a majority or more of the Members present and voting, which will be considered a clear and strong majority.

3. If the Board nominates one person, the Health Assembly shall decide by a two-thirds majority of the Members present and voting.

(Ninth plenary meeting, 27 May 2013 –
Committee B, second report)

WHA66.19 Real estate

The Sixty-sixth World Health Assembly,

Having considered the report on real estate;[1]

Having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-sixth World Health Assembly,[2]

APPROVES the construction of the new WHO sub-office in Garowe, Puntland Somalia.

(Ninth plenary meeting, 27 May 2013–
Committee B, second report)

WHA66.20 Agreement between the World Health Organization and the South Centre

The Sixty-sixth World Health Assembly,

Having considered the report on the proposed agreement between the World Health Organization and the South Centre;[3]

Considering also Article 70 of the Constitution of the World Health Organization,

[1] Document A66/42.

[2] Document A66/62.

[3] See document A66/46,.

APPROVES the proposed agreement between the World Health Organization and the South Centre.[1]

(Ninth plenary meeting, 27 May 2013 –
Committee B, second report)

WHA66.21 Reassignment of South Sudan from the Eastern Mediterranean Region to the African Region[2]

The Sixty-sixth World Health Assembly,

Having considered the request from the Government of South Sudan for the inclusion of that country in the African Region,[3]

RESOLVES that South Sudan shall form part of the African Region.

(Ninth plenary meeting, 27 May 2013 –
Committee B, second report)

WHA66.22 Follow up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination

The Sixty-sixth World Health Assembly,

Having considered the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination;[4]

Recalling resolution WHA65.22, which requested the Director-General, inter alia, to hold an open-ended meeting of Member States that would thoroughly analyse the report and the feasibility of the recommendations proposed by the Consultative Expert Working Group, and taking into account discussions during regional committee meetings and regional and national consultations;

Further recalling the global strategy and plan of action on public health, innovation and intellectual property and its aims to promote innovation, build capacity, improve access and mobilize resources to address diseases that disproportionately affect developing countries as well as resolutions WHA59.24, WHA63.21 and WHA63.28;

Recognizing the urgency in addressing the health needs of developing countries and the related inequities in the current research landscape due to recognized market failures and the need for enhancing investments in health 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;

Acknowledging the need for improving monitoring of health research and development resource flows, and identification of gaps in health research and development, better coordination of health

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[1] See Annex 4.

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

[3] See document A66/43.

[4] Document A66/23.

research and development, and priority-setting based on the public health needs of developing countries;

Acknowledging also that the provision of additional information on disease burden, research opportunities, and the potential health impact of new health products, as well as an estimation of the resources needed to develop new health products and make them accessible to the poor in developing countries, can provide an important basis for advocacy for additional financing;

Recognizing the importance of securing sustainable financing mechanisms for health research and development in order to develop and deliver health products that address the health needs of developing countries;

Recalling the global strategy and plan of action on public health, innovation and intellectual property, which refers to a range of incentive schemes for health research and development, with one objective being the de-linkage of the cost of research and development from the price of health products;

Recognizing the interlinkage of monitoring, coordination and financing of health research and development as well as the importance of predictability and sustainability of the resources required to enhance health research and development;

Reaffirming the importance of facilitation of technology transfer on mutually agreed terms between developed and developing countries as well as among developing countries as appropriate;

Underscoring that health research and development should be needs-driven and evidence-based, and be guided by the following core principles: affordability, effectiveness, efficiency and equity; and it should be considered as a shared responsibility;

Realizing the need for improving priority-setting and transparent decision-making processes based on the public health needs of developing countries;

Noting the important role of the public and private sectors in promoting innovation and developing new health products,

1. ENDORSES the following strategic workplan to improve monitoring and coordination, and to ensure sustainable funding for health research and development, in line with the global strategy and plan of action on public health, innovation and intellectual property, as a step towards achieving the goal of development and delivery of affordable, effective, safe and quality health products for which existing market mechanisms fail to provide incentives for health research and development; and agreeing to develop the strategic workplan further, through the broad engagement of public and private entities, academia and civil society;

2. URGES Member States:[1]

(1) to strengthen health research and development capacities, increasing investments in health research and development for diseases disproportionately affecting developing countries;

(2) to promote capacity building, transfer of technology on mutually agreed terms, manufacture of health products in developing countries, and health research and development

[1] And, where applicable, regional economic integration organizations.

and access to health products in developing countries through investments and sustainable collaboration;

(3) to establish or strengthen national health research and development observatories or equivalent functions for tracking and monitoring of relevant information on health research and development, in line with agreed norms and standards as established in subparagraph 4(1) below, and to contribute to the work of a global health research and development observatory;

(4) to promote coordination of health research and development at national, regional and global levels in order to maximize synergies;

(5) to identify projects, as part of the strategic workplan, through regional consultations and broad engagement of relevant stakeholders, to address research gaps, ensure effective coordination at all levels, and secure resource needs for implementation in order to develop and deliver health products;

(6) to continue consultation, at national as well as at regional and global levels, including through the governing bodies of WHO, on specific aspects related to coordination, priority setting and financing of health research and development;

(7) to contribute to coordinated and sustainable financing mechanisms for health research and development, through voluntary contributions for activities at country, regional and global levels, in particular for monitoring, including a global health research and development observatory;

3. CALLS upon all stakeholders, including the private sector, academic institutions and nongovernmental organizations:

(1) to share relevant information with WHO on health research and development in order to contribute to a global health research and development observatory;

(2) to contribute to the financing mechanisms;

4. REQUESTS the Director-General:

(1) to develop norms and standards for classification of health research and development, building on existing sources, in consultation with Member States and relevant stakeholders, in order to collect and collate information systematically;

(2) to support Member States in their endeavours to establish or strengthen health research and development capacities and monitor relevant information on health research and development;

(3) to establish a global health research and development observatory within the Secretariat in order to monitor and analyse relevant information on health research and development, building on national and regional observatories (or equivalent functions) and existing data collection mechanisms with a view to contributing to the identification of gaps and opportunities for health research and development and defining priorities in consultation with Member States, as well as, in collaboration with other relevant stakeholders, as appropriate, in order to support coordinated actions;

(4) to facilitate through regional consultations and broad engagement of relevant stakeholders the implementation of a few health research and development demonstration projects to address identified gaps that disproportionately affect developing countries, particularly the poor, and for which immediate action can be taken;

(5) to review existing mechanisms in order to assess their suitability to perform the coordination function of health research and development;

(6) to explore and evaluate existing mechanisms for contributions to health research and development and, if there is no suitable mechanism, to develop a proposal for effective mechanisms, including pooling resources and voluntary contributions, as well as a plan to monitor their effectiveness independently;

(7) to convene another open-ended meeting of Member States prior to the Sixty-ninth World Health Assembly in May 2016, in order to assess progress and continue discussions on the remaining issues in relation to monitoring, coordination and financing for health research and development, taking into account all relevant analyses and reports, including the analysis of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination;

(8) to report on the review of existing coordination mechanisms (referred to in subparagraph 4(5) above), as well as on the evaluation of existing mechanisms for contributions to health research and development (referred to in subparagraph 4(6) above) to the Sixty-seventh World Health Assembly, through the Executive Board at its 134th session; to report on the implementation of health research and development demonstration projects (referred to in subparagraph 4(4) above) to the Sixty-eighth World Health Assembly, through the Executive Board at its 136th session; and to transmit the report of the open-ended meeting of Member States to the Sixty-ninth World Health Assembly.

(Ninth plenary meeting, 27 May 2013 –
Committee B, fourth report)

WHA66.23 Transforming health workforce education in support of universal health coverage[1]

The Sixty-sixth World Health Assembly,

Recalling resolution WHA59.23 urging Member States to scale up health workforce production in response to the shortages of health workers that hamper the achievement of the internationally agreed health-related development goals, including those contained in the Millennium Declaration;

Recognizing that a functioning health system with an adequate number and equitable distribution of committed and competent health workers at the primary health care level is fundamental to equitable access to health services as an important objective of universal health coverage, and was highlighted in *The world health report 2006*;[2]

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

[2] *The world health report 2006: Working together for health*. Geneva, World Health Organization, 2006.

Recognizing also the need to provide adequate and reliable financial and non-financial incentives and an enabling and safe working environment for the retention of health workers in areas where they are most needed, especially in remote, hard-to-reach areas and urban slums, as recommended by WHO global guidelines;[1]

Recalling resolution WHA64.9 on sustainable health financing structures and universal coverage, which, inter alia, urged Member States to continue, as appropriate, to invest in and strengthen the health delivery systems, in particular primary health care and services, and adequate human resources for health and health information systems, in order to ensure that all citizens have equitable access to health care and services;

Concerned that in many countries, notably those in sub-Saharan Africa, there is inadequate capacity to train a sufficient number of health workers to provide the population with adequate service coverage;

Recognizing the specific challenges of some Member States that have limited economy of scale in local health workforce education, their special needs, and the potential partnerships and collaboration with other Member States;

Concerned also that the health workforce education challenge is global;

Concerned further that demographic projections highlight the supply and distribution of the health workforce as issues of concern in the coming decades, irrespective of countries' development status;

Recognizing also the need for intersectoral collaboration among the Ministry of Health, the Ministry of Education, public and private training institutions, and health professional organizations in strengthening the health workforce education system so as to produce competent health workforces that support universal health coverage;

Concerned also that many countries lack sufficient financial means, facilities and number of educators to train an adequate, competent health workforce; and that there is a need to improve the health workforce education and training system in response to countries' health needs;

Mindful of the need for Member States to develop comprehensive policies and plans on human resources for health, including health workforce education as one of the elements;

Recalling resolution WHA63.16 on the WHO Global Code of Practice on the International Recruitment of Health Personnel, in which Code, inter alia, Member States agreed to strive to create a sustainable health workforce and establish effective health workforce planning, education and training, as well as retention strategies;[2]

Recognizing the Dhaka Declaration on strengthening the health workforce in the countries of the South-East Asia Region and resolution SEA/RC65/R7 adopted by the Regional Committee for South-East Asia on strengthening health workforce education and training in the Region, which urged Member States, inter alia, to conduct comprehensive assessments of the current situation of health

[1] Increasing access to health workers in remote and rural areas through improved retention, global policy recommendations. Geneva, World Health Organization, 2010.

[2] Article 3 – Guiding principles, paragraph 3.6.

workforce education and training, based on an agreed regional common protocol, as a foundation for evidence-based policy formulation and implementation;

Recognizing also the recommendations contained in the Global Independent Commission report on health professionals for a new century: transforming education to strengthen health systems in an interdependent world;[1]

Appreciating the ongoing initiatives to strengthen health workforce education and training in various regions; including but not limited to the Medical and Nursing Education Partnership Initiative, in-service training of health workers in sub-Saharan Africa supported by Japan in line with the G8 Hokkaido Toyako Summit Leaders Declaration, and the Asia Pacific Network for Health Professional Education Reform,

1. URGES Member States:[2]

(1) to further strengthen policies, strategies and plans as appropriate, through intersectoral policy dialogue among the relevant ministries that may include ministries of education, health and finance, in order to ensure that health workforce education and training contribute to achieving universal health coverage;

(2) to consider conducting comprehensive assessments of the current situation of health workforce education with the application of, as appropriate, standard protocols and tools, once developed by WHO;

(3) to consider formulating and implementing evidence-based policies and strategies, taking into account the findings from the assessment in the previous paragraph, to strengthen and transform the health workforce education and training, including but not limited to the promotion of inter-professional, community-based and health systems-based education, linkages of pre-service education to continuous professional development, and an accreditation system to ensure quality of training institutes and competency of health workforces; with a view to better responding to the health needs of people, taking into account the special needs of some Member States that have limited economy of scale in local training;

(4) to provide adequate resources and political support for the implementation of policies and strategies as appropriate for the strengthening and transformation of health workforce education;

(5) to share best practices and experiences on health workforce education;

2. REQUESTS the Director-General:

(1) to develop a standard protocol and tool for assessment, which may be adapted to country context;

(2) to support Member States as appropriate in using the protocol to conduct comprehensive assessments of the current situation of health workforce education;

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[1] Education of health professionals for the 21st century: a Global Independent Commission. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world, The Lancet, Harvard University Press, Cambridge MA, 2010.

[2] And, where applicable, regional economic integration organizations.

(3) to provide technical support to Member States in formulating and implementing evidence-based policies and strategies in order to strengthen and transform their health workforce education;

(4) to consult regionally in order to review the country assessment findings and submit a report providing clear conclusions and recommendations, through the Executive Board, to the Sixty-ninth World Health Assembly;

(5) to develop, based on the report, global and regional approaches, which may include strategies to transform health workforce education, submitting these, through the Executive Board, for consideration by the Seventieth World Health Assembly.

(Ninth plenary meeting, 27 May 2013 –
Committee B, fourth report)

WHA66.24 eHealth standardization and interoperability[1]

The Sixty-sixth World Health Assembly,

Having considered the report by the Secretariat;[2]

Recalling resolution WHA58.28 on eHealth;

Recognizing that information and communication technologies have been incorporated in the Millennium Development Goals;

Recognizing also that the Regional Committee for Africa adopted resolution AFR/RC60/R3 on eHealth in the African Region and that the 51st Directing Council of the Pan American Health Organization adopted resolution CD51.R5 on eHealth and has approved the related Strategy and Plan of Action;[3]

Recognizing further that the secure, effective and timely transmission of personal data or population data across information systems requires adherence to standards on health data and related technology;

Recognizing also that it is essential to make appropriate use of information and communication technologies in order to improve care, to increase the level of engagement of patients in their own care, as appropriate, to offer quality health services, to support sustainable financing of health care systems, and to promote universal access;

Recognizing in addition that the lack of a seamless exchange of data within and between health information systems hinders care and leads to fragmentation of health information systems, and that improvement in this is essential to realize the full potential of information and communication technologies in health system strengthening;

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

[2] Document A66/26.

[3] See document CD/51/13.

Recognizing further that, through standardized electronic data: health workers can gain access to fuller and more accurate information in electronic form on patients at the point of care; pharmacies can receive prescriptions electronically; laboratories can transmit test results electronically; imaging and diagnostic centres have access to high-quality digital images; researchers can carry out clinical trials and analyse data with greater speed and accuracy; public health authorities have access to electronic reports on vital events in a timely manner, and can implement public health measures based on the analysis of health data; and individuals can gain access to their personal medical information, which supports patient empowerment;

Recognizing also that advances in medical health care, coupled with an exponential increase in the use of information and communication technologies in the health sector and other related fields, including the environment, have brought about a need to collect, store and process more data about patients and their environment in multiple computer and telecommunication systems and, therefore, ehealth standardization and interoperability should address standardization and interoperability issues related to hardware, systems, infrastructure, data and services;

Recognizing that the electronic collection, storage, processing and transmission of personal health data require adherence to the highest standards of data protection;

Recognizing further that the electronic transmission of personal or population data using health information systems based on information and communication technologies requires adherence to standards in health data and technology in order to achieve a secure, timely and accurate exchange of data for health decision-making;

Emphasizing that scientific evaluation of the impact on health care outcomes of health information systems based on information and communication technologies is necessary to justify strong investment in such technologies for health;

Highlighting the need for national eHealth strategies to be developed and implemented, in order to provide the necessary context for the implementation of ehealth and health data standards, and in order that countries undertake regular, scientific evaluation;

Recognizing that it is essential to ensure secure online management of health data, given their sensitive nature, and to increase trust in eHealth tools and health services as a whole;

Emphasizing that health-related global top-level domain names in all languages, including ".health", should be operated in a way that protects public health, including by preventing the further development of illicit markets of medicines, medical devices and unauthorized health products and services,

1. URGES Member States:[1]

(1) to consider, as appropriate, options to collaborate with relevant stakeholders, including national authorities, relevant ministries, health care providers, and academic institutions, in order to draw up a road map for implementation of ehealth and health data standards at national and subnational levels;

(2) to consider developing, as appropriate, policies and legislative mechanisms linked to an overall national eHealth strategy, in order to ensure compliance in the adoption of ehealth and

[1] And, where applicable, regional economic integration organizations.

health data standards by the public and private sectors, as appropriate, and the donor community, as well as to ensure the privacy of personal clinical data;

(3) to consider ways for ministries of health and public health authorities to work with their national representatives on the ICANN Governmental Advisory Committee in order to coordinate national positions towards the delegation, governance and operation of health-related global top-level domain names in all languages, including ".health", in the interest of public health;

2. REQUESTS the Director-General, within existing resources:

(1) to provide support to Member States, as appropriate, in order to integrate the application of ehealth and health data standards and interoperability in their national eHealth strategies through a multistakeholder and multisectoral approach including national authorities, relevant ministries, relevant private sector parties, and academic institutions;

(2) to provide support to Member States, as appropriate, in their promotion of the full implementation of ehealth and health data standards in all eHealth initiatives;

(3) to provide guidance and technical support, as appropriate, to facilitate the coherent and reproducible evaluation of information and communication technologies in health interventions, including a database of measurable impacts and outcome indicators;

(4) to promote full utilization of the network of WHO collaborating centres for health and medical informatics and eHealth in order to support Member States in related research, development and innovation in these fields;

(5) to promote, in collaboration with relevant international standardization agencies, harmonization of eHealth standards;

(6) to convey to the appropriate bodies, including the ICANN Governmental Advisory Committee and ICANN constituencies, the need for health-related global top-level domain names in all languages, including ".health", to be consistent with global public health objectives;

(7) to continue working with the appropriate entities, including the ICANN Governmental Advisory Committee and ICANN constituencies as well as intergovernmental organizations, towards the protection of the names and acronyms of intergovernmental organizations, including WHO, in the Internet domain name system;

(8) to develop a framework for assessing progress in implementing this resolution and report periodically, through the Executive Board, to the World Health Assembly, using that framework.

(Ninth plenary meeting, 27 May 2013 –
Committee B, fourth report)

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