



WORLD HEALTH ORGANIZATION

SIXTY-SIXTH WORLD HEALTH ASSEMBLY

GENEVA, 20–27 MAY 2013

**RESOLUTIONS AND DECISIONS
ANNEXES**

GENEVA
2013

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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

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

PREFACE

The Sixty-sixth World Health Assembly was held at the Palais des Nations, Geneva, from 20 to 27 May 2013, in accordance with the decision of the Executive Board at its 131st session.¹

¹ Decision EB131(10).

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¹ Adopted at the second plenary meeting.

² Including election of Vice-Chairmen and the Rapporteur.

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² See Annex 6.

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¹ See Annex 6.

² See Annex 5.

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A66/56	Scale of assessments for 2014–2015 Foreign exchange risk management Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-sixth World Health Assembly
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¹ See Annex 1.

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A66/INF./2	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan (report by the Ministry of Health of the Syrian Arab Republic)
A66/INF./3	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan (report of the Director of Health, UNRWA, for the year 2012)
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A66/DIV./2	Guide for delegates to the World Health Assembly
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A66/DIV./5	Address by Her Excellency Dr Nkosazana Dlamini Zuma, Chairperson of the African Union Commission, to the Sixty-sixth World Health Assembly
A66/DIV./6	Address by Ms Gunilla Carlsson, Minister for International Development Cooperation, Sweden to the Sixty-sixth World Health Assembly
A66/DIV./7	Address by Dr Jim Yong Kim, World Bank Group President, to the Sixty-sixth World Health Assembly

OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

President

Dr Shigeru OMI (Japan)

Vice-Presidents

Dr José V. DIAS VAN-DÚNEM (Angola)
Dr Ahmed bin Mohamed bin Obaid
AL SAIDI (Oman)
Mr Vidyadhar MALLIK (Nepal)
Professor Raisa BOGATYRYOVA (Ukraine)
Dr Florence DUPerval GUILLAUME
(Haiti)

Secretary

Dr Margaret CHAN, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Afghanistan, Canada, Cook Islands, Malawi, Mali, Mongolia, Nicaragua, Republic of Moldova, Romania, Sri Lanka, Turkey, Uganda

Chairman: Dr R. WIMAL JAYANTHA
(Sri Lanka)

Vice-Chairman: Ms Roxana ROTOCOL
(Romania)

Secretary: Ms Joanne McKEOUGH
(Principal Legal Officer)

General Committee

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the Chairmen of the main committees, together with delegates of the following Member States: Chile, China, Cuba, Fiji, France, Honduras, Iraq, Ireland,

Kazakhstan, Namibia, Russian Federation, Rwanda, Sao Tome and Principe, South Africa, Thailand, United States of America, Yemen

Chairman: Dr Shigeru OMI (Japan)

Secretary: Dr Margaret CHAN, Director-General

MAIN COMMITTEES

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

Committee A

Chairman: Dr Walter T. GWENIGALE
(Liberia)

Vice-Chairmen: Dr Lester G. ROSS
(Solomon Islands) and Dr Sania NISHTAR
(Pakistan)

Rapporteur: Dr Victor CUBA ORÉ (Peru)

Secretary: Dr Timothy ARMSTRONG,
Coordinator, Surveillance and Population-
based Prevention

Committee B

Chairman: Mrs Kathryn TYSON (United
Kingdom of Great Britain and Northern
Ireland)

Vice-Chairmen: Dr Daisy CORRALES DÍAZ
(Costa Rica) and Dr Poonam Khetrpal
SINGH (India)

Rapporteur: Mr Jilali HAZIM (Morocco)

Secretary: Dr Clive ONDARI, Coordinator,
Medicines Access and Rational Use

REPRESENTATIVES OF THE EXECUTIVE BOARD

Dr Joy ST. JOHN (Barbados)

Dr REN Minghui (China)

Dr Ahmed Jamsheed MOHAMED (Maldives)

RESOLUTIONS AND DECISIONS

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 2014–2019³

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:
 - (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;

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.

(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 Golan¹

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;

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;²

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

² Document A66/28.

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 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)

**WHA66.7 Implementation of the recommendations of the United Nations
Commission on Life-Saving Commodities for Women and Children³**

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;⁴

¹ Document A66/29.

² Document A66/54.

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

⁴ Document A66/14.

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 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,

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 United Nations 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 stage¹

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 2013–2020²

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 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.

1. ADOPTS the comprehensive mental health action plan 2013–2020;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 Disability²

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;

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,

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 States¹ 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 Diseases²

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 Communiqué 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

¹As 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 indicators¹ 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,¹ 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, and which would be convened and led by WHO and report to the Economic and Social Council, 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 3(2) through a formal Member States¹ 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 2013–2020,³ 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 global action plan.³

(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.

³ Annex 4.

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 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 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 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 development agenda are inclusive and open to all regions, subregions and Member States,¹ and that such discussions are adequately informed by other ongoing processes;
- (2) to continue active engagement with ongoing discussions on the post-2015 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 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.

WHA66.12 Neglected tropical diseases¹

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;³

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

² Document A66/20.

³ Document WHO/HTM/NTD/2012.1.

1. URGES Member States:

- (1) to ensure continued country ownership of programmes for neglected tropical disease prevention, control, elimination and eradication;
- (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 chemotherapy¹ 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
2021	36 651
2022	36 654
Total	366 513

¹ Document A66/30.

² Document A66/45.

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
Botswana	0.0170
Brazil	2.9342
Brunei Darussalam	0.0260
Bulgaria	0.0470
Burkina Faso	0.0030

¹ Document A66/31.

Members and Associate Members	WHO scale for 2014–2015 %
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
India	0.6660
Indonesia	0.3460
Iran (Islamic Republic of)	0.3560
Iraq	0.0680
Ireland	0.4180

Members and Associate Members	WHO scale for 2014–2015
	%
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
Paraguay	0.0100
Peru	0.1170
Philippines	0.1540
Poland	0.9211
Portugal	0.4740

Members and Associate Members	WHO scale for 2014–2015 %
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
United States of America	22.0000
Uruguay	0.0520
Uzbekistan	0.0150
Vanuatu	0.0010
Venezuela (Bolivarian Republic of)	0.6270

Members and Associate Members	WHO scale for 2014–2015
	%
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 reports 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:²

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.

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

¹ Documents A66/32 and A66/56.

² See Annex 1.

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 Organization³

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 *70bis*, as set out in Annex 4 to this resolution;

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 States¹ 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

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

Address to which correspondence should be sent:	Telephone: Mobile phone: Fax: E-mail:
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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
<p>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.</p> <p>CODE: 1. Limited conversation, reading of newspapers, routine correspondence.</p>	Arabic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Chinese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	French	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Spanish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Russian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others (please specify)					
2. Engage freely in discussions, read and write more difficult material					
3. Fluent (nearly) as in mother tongue					

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 Region²

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

¹ See Annex 5.

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 coverage¹

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;

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 interoperability¹

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)

DECISIONS

WHA66(1) Composition of the Committee on Credentials

The Sixty-sixth World Health Assembly appointed a Committee on Credentials consisting of delegates of the following Member States: Afghanistan, Canada, Cook Islands, Malawi, Mali, Mongolia, Nicaragua, Republic of Moldova, Romania, Sri Lanka, Turkey, Uganda.

(First plenary meeting, 20 May 2013)

WHA66(2) Election of officers of the Sixty-sixth World Health Assembly

The Sixty-sixth World Health Assembly elected the following officers:

President: Dr Shigeru Omi (Japan)

Vice-Presidents: Dr José V. Dias Van-Dúnem (Angola)
Dr Ahmed bin Mohamed bin Obaid Al Saidi (Oman)
Mr Vidyadhar Mallik (Nepal)
Professor Raisa Bogatyryova (Ukraine)
Dr Florence Duperval Guillaume (Haiti)

(First plenary meeting, 20 May 2013)

WHA66(3) Establishment of the General Committee

The Sixty-sixth World Health Assembly elected the delegates of the following 17 countries as members of the General Committee: Chile, China, Cuba, Fiji, France, Honduras, Iraq, Ireland, Kazakhstan, Namibia, Russian Federation, Rwanda, Sao Tome and Principe, South Africa, Thailand, United States, Yemen.

(First plenary meeting, 20 May 2013)

WHA66(4) Adoption of the agenda

The Sixty-sixth World Health Assembly adopted the provisional agenda prepared by the Executive Board at its 132nd session, with the deletion of two items and the transfer of one item from Committee B to Committee A.

(Second plenary meeting, 20 May 2013)

WHA66(5) Election of officers of the main committees

The Sixty-sixth World Health Assembly elected the following officers of the main committees:

Committee A:	Chairman	Dr Walter T. Gwenigale (Liberia)
Committee B:	Chairman	Mrs Kathryn Tyson (United Kingdom of Great Britain and Northern Ireland)

(First plenary meeting, 20 May 2013)

The main committees subsequently elected the following officers:

Committee A:	Vice-Chairmen	Dr Lester Ross (Solomon Islands) Dr Sania Nishtar (Pakistan)
	Rapporteur	Dr Victor Cuba Oré (Peru)
Committee B:	Vice-Chairmen	Dr Daisy Corrales Diaz (Costa Rica) Dr Poonam Khetrapal Singh (India)
	Rapporteur	Mr Jilali Hazim (Morocco)

(First meetings of Committees A and B, 20 and 22 May 2013, respectively)

WHA66(6) Verification of credentials

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

(Sixth plenary meeting, 22 May 2013)

WHA66(7) Election of Members entitled to designate a person to serve on the Executive Board

The Sixty-sixth World Health Assembly, after considering the recommendations of the General Committee, elected the following as Members entitled to designate a person to serve on the Executive Board: Albania, Andorra, Argentina, Brazil, Democratic People's Republic of Korea, Egypt, Japan, Namibia, Republic of Korea, Saudi Arabia, South Africa, Suriname.

(Eighth plenary meeting, 24 May 2013)

WHA66(8) Financing of WHO

The Sixty-sixth World Health Assembly decided to establish a 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, with the first financing dialogue on the Programme budget 2014–2015 to take place in 2013, in accordance with the modalities described in document A66/48.

(Eighth plenary meeting, 24 May 2013)

WHA66(9) Strategic resource allocation methodology

The Sixty-sixth World Health Assembly decided to request the Director-General to propose, for consideration by the Sixty-seventh World Health Assembly, in consultation with Member States, a new strategic resource allocation methodology in WHO, starting with the programme budget for 2016–2017, utilizing a robust, bottom-up planning process and realistic costing of outputs, based on clear roles and responsibilities across the three levels of WHO.

(Eighth plenary meeting, 24 May 2013)

WHA66(10) Substandard/spurious/falsely-labelled/falsified/counterfeit medical products

The Sixty-sixth World Health Assembly, having considered the report on substandard/spurious/falsely-labelled/falsified/counterfeit medical products,¹ decided to recommend that the chairmanship of the Steering Committee on the Member State mechanism on substandard/spurious/falsely-labelled/falsified/counterfeit medical products operate on the basis of rotation, on an interim basis, without prejudice to the existing terms of reference for the mechanism.

(Ninth plenary meeting, 27 May 2013)

WHA66(11) Appointment of representatives to the WHO Staff Pension Committee

(1) The Sixty-sixth World Health Assembly nominated Dr Viroj Tangcharoensathien of the delegation of Thailand as a member for a three-year term until May 2016 and the most senior alternate member, Mrs Palanitina Tupuimatagi Toelupe of the delegation of Samoa, as a member for the remainder of her term of office until May 2014.

¹ Document A66/22.

(2) The Sixty-sixth World Health Assembly nominated Dr Mahmoud N. Fikry of the delegation of United Arab Emirates and Mr Alejandro Henning of the delegation of Argentina as alternate members of the WHO Staff Pension Committee for three-year terms until May 2016.

(Ninth plenary meeting, 27 May 2013)

WHA66(12) Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination

(1) The Sixty-sixth World Health Assembly requested the Director-General, in order to take forward action in relation to monitoring, coordination and financing for health research and development, and in line with resolution WHA66.22, to convene a technical consultative meeting over two to three days in order to assist in the identification of demonstration projects that:

- (a) address identified research and development gaps related to discovery, development and/or delivery, including promising product pipelines, for diseases that disproportionately affect developing countries, particularly the poor, and for which immediate action can be taken;
- (b) utilize collaborative approaches, including open-knowledge approaches, for research and development coordination;
- (c) promote the de-linkage of the cost of research and development from product price; and
- (d) propose and foster financing mechanisms including innovative, sustainable and pooled funding;

(2) The demonstration projects should provide evidence for long-term sustainable solutions;

(3) The technical consultative meeting will be open to all Member States.¹ The Director-General shall invite experts from relevant health research and development fields and experts with experience in managing funds for research and development while safeguarding WHO and public health from undue influence by any form of real, perceived or potential conflicts of interest;

(4) The Director-General shall consult with regional directors in accordance with established WHO practice in order to ensure regional representation and diversity of expertise and experience;

(5) The meeting will be in two parts: firstly a technical discussion among the experts followed by a briefing to and discussion by Member States;

(6) The meeting should be held by the end of 2013 and should be complementary to the regional consultations referred to in operative paragraphs 2(6) and 4(4) of resolution WHA66.22;

(7) A report of the meeting will be presented by the Director-General to the Executive Board at its 134th session.

(Ninth plenary meeting, 27 May 2013)

¹ And, where applicable, regional economic integration organizations.

WHA66(13) Selection of the country in which the Sixty-seventh World Health Assembly would be held

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

(Ninth plenary meeting, 27 May 2013)

ANNEXES

ANNEX 1

Text of the amended Financial Regulations of the World Health Organization¹

[A66/32 – 22 March 2013,
A66/33 – 15 May 2013,
A66/56 – 20 May 2013 and
A66/57 – 20 May 2013]

FINANCIAL REGULATIONS

Regulation IV – Budget Approval

4.1 The budget approved by the Health Assembly shall constitute an authorization to the Director-General to incur contractual obligations and make payments for the purposes for which the budget was approved and up to the amounts so approved, subject to available funding.

4.2 Once the budget has been approved, commitments can be made by the Director-General in the financial period to which they relate for delivery in that financial period or the subsequent calendar year, subject to available funding.

...

Regulation V – Provision of Budget Funds

5.1 The budget shall be financed by assessed contributions from Members, according to the scale of assessments determined by the Health Assembly, by voluntary contributions, by projected interest earned, prior period collection of arrears and any other income attributable to the budget. Members' financial obligations under Article 56 of the WHO Constitution are limited to the assessed contributions.

5.2 The Health Assembly shall approve the amount to be financed by assessed contributions from Member States, and shall approve the amount to be raised by the Director-General from voluntary sources.

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

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

¹ Text amended in accordance with resolutions WHA66.3 and WHA66.16.

5.4 Assessed contributions are made available for implementation on 1 January of each year of the financial period. Voluntary contributions are made available for implementation upon recording of agreements with the resource contributors.

5.5 The Director-General shall submit to the Health Assembly annual reports on the collection of contributions (both voluntary and assessed), and other sources of cash.

Regulation VI – Assessed Contributions

...

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

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

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

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

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.

...

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

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

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

Regulation VII – Working Capital Fund and Internal Borrowing

7.1 Pending the receipt of assessed contributions, implementation of that part of the budget financed from these contributions may be financed from the Working Capital Fund and thereafter by internal

borrowing. The amount of the Working Capital Fund is approved by the Health Assembly. Internal borrowing may be made against available cash reserves of the Organization, excluding Trust Funds.

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

...

ANNEX 2

Universal eye health: a global action plan 2014–2019¹

[A66/11 – 28 March 2013]

1. In January 2012 the Executive Board reviewed progress made in implementing the action plan for the prevention of avoidable blindness and visual impairment for the period 2009–2013. It decided that work should commence immediately on a follow-up plan for the period 2014–2019, and requested the Director-General to develop a draft action plan for the prevention of avoidable blindness and visual impairment for the period 2014–2019 in close consultation with Member States and international partners, for submission to the World Health Assembly through the Executive Board.² The following global action plan was drafted after consultations with Member States, international partners and organizations in the United Nations system.

VISUAL IMPAIRMENT IN THE WORLD TODAY

2. For 2010, WHO estimated that globally 285 million people were visually impaired, of whom 39 million were blind.

3. According to the data for 2010, 80% of visual impairment including blindness is avoidable. The two main causes of visual impairment in the world are uncorrected refractive errors (42%) and cataract (33%). Cost-effective interventions to reduce the burden of both conditions exist in all countries.

4. Visual impairment is more frequent among older age groups. In 2010, 82% of those blind and 65% of those with moderate and severe blindness were older than 50 years of age. Poorer populations are more affected by visual impairment including blindness.

BUILDING ON THE PAST

5. In recent resolutions, the Health Assembly has highlighted the importance of eliminating avoidable blindness as a public health problem. In 2009, the World Health Assembly adopted resolution WHA62.1, which endorsed the action plan for the prevention of avoidable blindness and visual impairment. In 2012, a report noted by the Sixty-fifth World Health Assembly and a discussion paper described lessons learnt from implementing the action plan for 2009–2013. The results of those findings and the responses received to the discussion paper were important elements in the development of this action plan. Some of the lessons learnt are set out below.

(a) *In all countries it is crucial to assess the magnitude and causes of visual impairment and the effectiveness of services.* It is important to ensure that systems are in place for monitoring prevalence and causes of visual impairment, including changes over time, and the effectiveness of eye care and rehabilitation services as part of the overall health system. Monitoring and

¹ See resolution WHA66.4.

² See decision EB130(1).

evaluating eye care services and epidemiological trends in eye disease should be integrated into national health information systems. Information from monitoring and evaluation should be used to guide the planning of services and resource allocation.

(b) *Developing and implementing national policies and plans for the prevention of avoidable visual impairment remain the cornerstone of strategic action.* Some programmes against eye diseases have had considerable success in developing and implementing policies and plans, however, the need remains to integrate eye disease control programmes into wider health care delivery systems, and at all levels of the health care system. This is particularly so for human resource development, financial and fiscal allocations, effective engagement with the private sector and social entrepreneurship, and care for the most vulnerable communities. In increasing numbers, countries are acquiring experience in developing and implementing effective eye health services and embedding them into the wider health system. These experiences need to be better documented and disseminated so that all countries can benefit from them.

(c) *Governments and their partners need to invest in reducing avoidable visual impairment through cost-effective interventions and in supporting those with irreversible visual impairment to overcome the barriers that they face in accessing health care, rehabilitation, support and assistance, their environments, education and employment.* There are competing priorities for investing in health care, nevertheless, the commonly used interventions to operate on cataracts and correct refractive errors – the two major causes of avoidable visual impairment – are highly cost effective. There are many examples where eye care has been successfully provided through vertical initiatives, especially in low-income settings. It is important that these are fully integrated into the delivery of a comprehensive eye care service within the context of wider health services and systems. The mobilization of adequate, predictable and sustained financial resources can be enhanced by including the prevention of avoidable visual impairment in broader development cooperative agendas and initiatives. Over the past few years, raising additional resources for health through innovative financing has been increasingly discussed but investments in the reduction of the most prevalent eye diseases have been relatively absent from the innovative financing debate and from major financial investments in health. Further work on a cost–benefit analysis of prevention of avoidable visual impairment and rehabilitation is needed to maximize the use of resources that are already available.

(d) *International partnerships and alliances are instrumental in developing and strengthening effective public health responses for the prevention of visual impairment.* Sustained, coordinated international action with adequate funding has resulted in impressive achievements, as demonstrated by the former Onchocerciasis Control Programme, the African Programme for Onchocerciasis Control and the WHO Alliance for the Global Elimination of Trachoma by the year 2020. VISION 2020: The Right to Sight, the joint global initiative for the elimination of avoidable blindness of WHO and the International Agency for the Prevention of Blindness, has been important in increasing awareness of avoidable blindness and has resulted in the establishment of regional and national entities that facilitate a broad range of activities. The challenge now is to strengthen global and regional partnerships, ensure they support building strong and sustainable health systems, and make partnerships ever more effective.

(e) *Elimination of avoidable blindness depends on progress in other global health and development agendas,* such as the development of comprehensive health systems, human resources for health development, improvements in the area of maternal, child and reproductive health, and the provision of safe drinking-water and basic sanitation. Eye health should be included in broader noncommunicable and communicable disease frameworks, as well as those addressing ageing populations. The proven risk factors for some causes of blindness (e.g. diabetes mellitus, smoking, premature birth, rubella and vitamin A deficiency) need to be continuously addressed through multisectoral interventions.

(f) *Research is important and needs to be funded.* Biomedical research is important in developing new and more cost-effective interventions, especially those that are applicable in low-income and middle-income countries. Operational research will provide evidence on ways to overcome barriers in service provision and uptake, and improvements in appropriate cost-effective strategies and approaches for meeting ever-growing public health needs for improving and preserving eye health in communities.

(g) *Global targets and national indicators are important.* A global target provides clarity on the overall direction of the plan and focuses the efforts of partners. It is also important for advocacy purposes and evaluating the overall impact of the action plan. National indicators help Member States and their partners to evaluate progress and plan future investments.

GLOBAL ACTION PLAN 2014–2019

6. The **vision** of the global action plan is a world in which nobody is needlessly visually impaired, where those with unavoidable vision loss can achieve their full potential, and where there is universal access to comprehensive eye care services.

7. The global action plan 2014–2019 aims to sustain and expand efforts by Member States, the Secretariat and international partners to further improve eye health and to work towards attaining the vision just described. Its **goal** is to reduce avoidable visual impairment¹ as a global public health problem and to secure access to rehabilitation services for the visually impaired. The **purpose** of the action plan is to achieve this goal by improving access to comprehensive eye care services that are integrated into health systems. Further details are provided in Appendix 1. Five principles and approaches underpin the plan: universal access and equity, human rights, evidence-based practice, a life course approach, and empowerment of people with visual impairment. Further details are provided in Appendix 2.

8. Proposed **actions** for Member States, international partners and the Secretariat are structured around three **objectives** (see Appendix 3):

Objective 1 addresses the need for generating evidence on the magnitude and causes of visual impairment and eye care services and using it to advocate greater political and financial commitment by Member States to eye health.

Objective 2 encourages the development and implementation of integrated national eye health policies, plans and programmes to enhance universal eye health with activities in line with WHO's framework for action for strengthening health systems to improve health outcomes.²

Objective 3 addresses multisectoral engagement and effective partnerships to strengthen eye health.

Each of the three objectives has a set of **metrics** to chart progress.

¹ The term "visual impairment" includes moderate and severe visual impairment as well as blindness. "Blindness" is defined as a presenting visual acuity of worse than 3/60 or a corresponding visual field loss to less than 10° in the better eye. "Severe visual impairment" is defined as a presenting visual acuity of worse than 6/60 and equal to or better than 3/60. "Moderate visual impairment" is defined as a presenting visual acuity in the range from worse than 6/18 to 6/60 (*Definition of visual impairment and blindness*. Geneva, World Health Organization, 2012.) The action plan uses the term "visual impairment". Also, see the ICD update and revision platform "Change the definition of blindness".

² *Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action*. World Health Organization. Geneva, 2007.

9. There are three **indicators** at the goal and purpose levels to measure progress at the national level, although many Member States will wish to collect more. The three indicators comprise: (i) the prevalence and causes of visual impairment; (ii) the number of eye care personnel; and (iii) cataract surgery. Further details are provided in Appendix 4.

- **Prevalence and causes of visual impairment.** It is important to understand the magnitude and causes of visual impairment and trends over time. This information is crucial for resource allocation, planning, and developing synergies with other programmes.
- **Number of eye care personnel, broken down by cadre.** This parameter is important in determining the availability of the eye health workforce. Gaps can be identified and human resource plans adjusted accordingly.
- **Cataract surgical service delivery. Cataract surgical rate** (number of cataract surgeries performed per year, per million population) and **cataract surgical coverage** (number of individuals with bilateral cataract causing visual impairment, who have received cataract surgery on one or both eyes). Knowledge of the surgery rate is important for monitoring surgical services for one of the leading causes of blindness globally, and the rate also provides a valuable proxy indicator for eye care service provision. Where Member States have data on the prevalence and causes of visual impairment, coverage for cataract surgery can be calculated; it is an important measure that provides information on the degree to which cataract surgical services are meeting needs.

10. For the first of these indicators there is a **global target**. It will provide an overall measure of the impact of the action plan. As a global target, the reduction in prevalence of avoidable visual impairment by 25% by 2019 from the baseline of 2010 has been selected for this action plan.¹ In meeting this target, the expectation is that greatest gains will come through the reduction in the prevalence of avoidable visual impairment in that portion of the population representing those who are over the age of 50 years. As described above, cataract and uncorrected refractive errors are the two principal causes of avoidable visual impairment, representing 75% of all visual impairment, and are more frequent among older age groups. By 2019, it is estimated that 84% of all visual impairment will be among those aged 50 years or more. Expanding comprehensive integrated eye care services that respond to the major causes of visual impairment, alongside the health improvement that can be expected to come from implementing wider development initiatives including strategies such as the draft action plan for the prevention and control of noncommunicable diseases 2013–2020, and global efforts to eliminate trachoma suggest the target, albeit ambitious, is achievable. In addition, wider health gains coming from the expected increase in the gross domestic product in low-income and middle-income countries will have the effect of reducing visual impairment.²

¹ The global prevalence of avoidable visual impairment in 2010 was 3.18%. A 25% reduction means that the prevalence by 2019 would be 2.37%.

² According to the International Monetary Fund, by 2019 the average gross domestic product per capita based on purchasing power parity will grow by 24% in low-income and lower-middle-income countries, by 22% in upper-middle-income countries, and by 14% in high-income countries.

APPENDIX 1

VISION, GOAL AND PURPOSE

VISION			
A world in which nobody is needlessly visually impaired, where those with unavoidable vision loss can achieve their full potential, and where there is universal access to comprehensive eye care services			
Goal	Measurable indicators¹	Means of verification	Important assumptions
To reduce avoidable visual impairment as a global public health problem and secure access to rehabilitation services for the visually impaired ²	Prevalence and causes of visual impairment <i>Global target: reduction in prevalence of avoidable visual impairment by 25% by 2019 from the baseline of 2010</i>	Collection of epidemiological data at national and subnational levels and development of regional and global estimates	Human rights conventions implemented, equity across all policies achieved, and people with visual impairment fully empowered Sustained investment achieved by the end of the action plan
Purpose			
To improve access to comprehensive eye care services that are integrated into health systems	Number of eye care personnel per million population Cataract surgical rate	Reports summarizing national data provided by Member States	Services accessed fully and equitably by all populations

¹ See also Appendix 4.

² The objective of the Secretariat's programme for the prevention of blindness was "to prevent and control major avoidable causes of blindness and to make essential eye care available to all ... the long-term target being to reduce national blindness rates to less than 0.5%, with no more than 1% in individual communities", Formulation and management of national programmes for the prevention of blindness. Geneva, World Health Organization, 1990 (document WHO/PBL/90.18).

APPENDIX 2

CROSS-CUTTING PRINCIPLES AND APPROACHES

Universal access and equity	Human rights	Evidence-based practice	Life course approach	Empowerment of people with blindness and visual impairment
All people should have equitable access to health care and opportunities to achieve or recover the highest attainable standard of health, regardless of age, gender or social position	Strategies and interventions for treatment, prevention and promotion must be compliant with international human rights conventions and agreements	Strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and good practice	Eye health and related policies, plans and programmes need to take account of health and social needs at all stages of the life course	People who are blind or who have low vision can participate fully in the social, economic, political and cultural aspects of life

APPENDIX 3

OBJECTIVES AND ACTIONS

Objective 1	Measurable indicators	Means of verification	Important assumptions
Evidence generated and used to advocate increased political and financial commitment of Member States for eye health	<p>Number of Member States that have undertaken and published prevalence surveys during the past five years by 2019</p> <p>Number of Member States that have completed and published an eye care service assessment over last five years in 2019</p> <p>Observation of World Sight Day reported by Member States</p>	<p>Epidemiological and economic assessment on the prevalence and causes of visual impairment reported to the Secretariat by Member States</p> <p>Eye care service assessment and cost-effectiveness research results used to formulate national and subnational policies and plans for eye health</p> <p>Reports of national, regional and global advocacy and awareness-raising events</p>	Advocacy successful in increasing investment in eye health despite the current global financial environment and competing agendas
Actions for Objective 1	Proposed inputs from Member States	Inputs from the Secretariat	Proposed inputs from international partners
1.1 Undertake population-based surveys on prevalence of visual impairment and its causes	<p>Undertake surveys in collaboration with partners, allocating resources as required</p> <p>Publish and disseminate survey results, and send them to the Secretariat</p>	<p>Provide Member States with tools for surveys and technical advice</p> <p>Provide estimates of prevalence at regional and global levels</p>	<p>Advocate the need for surveys</p> <p>Identify and supply additional resources to complement governments' investments in surveys</p>
1.2 Assess the capacity of Member States to provide comprehensive eye care services and identify gaps	<p>Assess eye care service delivery, allocating resources as required. Assessments should cover availability, accessibility, affordability, sustainability, quality and equity of services provided, including cost-effectiveness analysis of eye health programmes</p> <p>Collect and compile data at national level, identifying gaps in service provision</p> <p>Publish and disseminate survey results,</p>	<p>Provide Member States with tools for eye care service assessments and technical advice</p> <p>Publish and disseminate reports that summarize data provided by Member States and international partners</p>	<p>Advocate the need for eye care service assessments</p> <p>Support Member States in collection and dissemination of data</p> <p>Identify and supply additional resources to complement governments' investments in eye care service assessments</p>

	and report them to the Secretariat		
1.3 Document, and use for advocacy, examples of best practice in enhancing universal access to eye care	Identify and document successful interventions and lessons learnt Publish results and report them to the Secretariat	Develop tools and provide them to Member States along with technical advice Collate and disseminate reports from Member States	Advocate the need to document best practice Support Member States in documenting best practice and disseminating results Identify additional resources to complement governments' investments
Objective 2	Measurable indicators	Means of verification	Important assumptions
National eye health policies, plans and programmes for enhancing universal eye health developed and/or strengthened and implemented in line with WHO's framework for action for strengthening health systems in order to improve health outcomes	Number of Member States reporting the implementation of policies, plans and programmes for eye health Number of Member States with an eye health/prevention of blindness committee, and/or a national prevention of blindness coordinator, or equivalent mechanism in place Number of Member States that include eye care sections in their national lists of essential medicines, diagnostics and health technologies Number of Member States that report the integration of eye health into national health plans and budgets Number of Member States that report a national plan that includes human resources for eye care Number of Member States reporting evidence of research on the cost-effectiveness of eye health programmes	Reports that summarize data provided by Member States	Policies, plans and programmes have sufficient reach for all populations Services accessed by those in need

Actions for Objective 2	Proposed inputs from Member States	Inputs from the Secretariat	Proposed inputs from international partners
<p>2.1 Provide leadership and governance for developing/updating, implementing and monitoring national/subnational policies and plans for eye health</p>	<p>Develop/update national/subnational policies, plans and programmes for eye health and prevention of visual impairment, including indicators and targets, engaging key stakeholders</p> <p>Secure inclusion of primary eye care into primary health care</p> <p>Establish new and/or maintain the existing coordinating mechanisms (e.g. national coordinator, eye health/prevention of blindness committee, other national/subnational mechanisms) to oversee implementation and monitoring/evaluating the policies, plans and programmes</p>	<p>Provide guidance to Member States on how to develop and implement national and subnational policies, plans and programmes in line with the global action plan</p> <p>Provide Member States with tools and technical advice on primary eye care, and evidence on good leadership and governance practices in developing, implementing, monitoring and evaluating comprehensive and integrated eye care services</p> <p>Establish/maintain global and regional staff with responsibility for eye health/prevention of visual impairment</p> <p>Establish country positions for eye health/prevention of visual impairment where strategically relevant and resources allow</p>	<p>Advocate national/subnational leadership for developing policies, plans and programmes</p> <p>Support national leadership in identifying the financial and technical resources required for implementing the policies/plans and inclusion of primary eye care in primary health care</p> <p>Secure funding for key positions in the Secretariat at headquarters, regional and country levels</p>
<p>2.2 Secure adequate financial resources to improve eye health and provide comprehensive eye care services integrated into health systems through national policies, plans and programmes</p>	<p>Ensure funding for eye health within a comprehensive integrated health care service</p> <p>Perform cost–benefit analysis of prevention of avoidable visual impairment and rehabilitation services and conduct research on the cost–effectiveness of eye health programmes to optimize the use of available resources</p>	<p>Provide tools and technical support to Member States in identifying cost–effective interventions and secure the financial resources needed</p>	<p>Advocate at national and international levels for adequate funds and their effective use to implement national/subnational policies, plans and programmes</p> <p>Identify sources of funds to complement national investment in eye care services and cost–benefit analyses</p>

<p>2.3 Develop and maintain a sustainable workforce for the provision of comprehensive eye care services as part of the broader human resources for health workforce</p>	<p>Undertake planning of human resources for eye care as part of wider human resources for health planning, and human resources for eye health planning in other relevant sectors</p> <p>Provide training and career development for eye health professionals</p> <p>Ensure retention strategies for eye health staff are in place and being implemented</p> <p>Identify, document and disseminate best practice to the Secretariat and other partners with regard to human resources in eye health</p>	<p>Provide technical assistance as required</p> <p>Collate and publish examples of best practice</p>	<p>Advocate the importance of a sustainable eye health workforce</p> <p>Support training and professional development through national coordination mechanisms</p> <p>Provide support to Member States in collection and dissemination of data</p>
<p>2.4 Provide comprehensive and equitable eye care services at primary, secondary and tertiary levels, incorporating national trachoma and onchocerciasis elimination activities</p>	<p>Provide and/or coordinate universal access to comprehensive and equitable eye care services, with emphasis on vulnerable groups such as children and the elderly</p> <p>Strengthen referral mechanisms, and rehabilitation services for the visually impaired</p> <p>Establish quality standards and norms for eye care</p>	<p>Provide WHO's existing tools and technical support to Member States</p>	<p>Advocate the importance of comprehensive and equitable eye care services</p> <p>Support local capacity building for provision of eye care services, including rehabilitation services in line with policies, plans and programmes through national coordination mechanisms</p> <p>Monitor, evaluate and report on services provided in line with national policies, plans and programmes through national coordination mechanisms</p>
<p>2.5 Make available and accessible essential medicines, diagnostics and health technologies of assured quality with particular focus on vulnerable groups and underserved communities, and explore mechanisms to increase affordability of new evidence-based technologies</p>	<p>Ensure existence of a national list of essential medical products, national diagnostic and treatment protocols, and relevant equipment</p> <p>Ensure the availability and accessibility of essential medicines, diagnostics and health technologies</p>	<p>Provide technical assistance and tools to support Member States</p>	<p>Advocate the importance of essential medicines, diagnostics and health technologies</p> <p>Provide essential medicines, diagnostics and health technologies in line with national policies</p>

2.6 Include indicators for the monitoring of provision of eye care services and their quality in national information systems	Adopt a set of national indicators and targets, including those on rehabilitation, within the national information systems Periodically collect, analyse and interpret data Report data to the Secretariat	Provide technical support to Member States by including national indicators and targets in national health systems Collate and disseminate data reported by Member States annually	Advocate the importance of monitoring using nationally agreed indicators Provide financial and technical support for collection and analysis of national and subnational data
Objective 3	Measurable indicators	Means of verification	Important assumptions
Multisectoral engagement and effective partnerships for improved eye health strengthened	Number of Member States that refer to a multisectoral approach in their national eye health/prevention of blindness policies, plans and programmes The WHO Alliance for the Global Elimination of Trachoma by the Year 2020, African Programme for Onchocerciasis Control, and Onchocerciasis Elimination Program for the Americas deliver according to their strategic plans Number of Member States that have eye health incorporated into relevant poverty-reduction strategies, initiatives and wider socioeconomic policies Number of Member States reporting eye health as a part of intersectoral collaboration	Reports from Member States received and collated by the Secretariat Receipt of annual reports and publications from partnerships	Non-health sectors invest in wider socioeconomic development

Actions for Objective 3	Proposed inputs from Member States	Inputs from the Secretariat	Proposed inputs from international partners
3.1 Engage non-health sectors in developing and implementing eye health/prevention of visual impairment policies and plans	<p>Health ministries identify and engage other sectors, such as those under ministries of education, finance, welfare and development</p> <p>Report experiences to the Secretariat</p>	<p>Advise Member States on specific roles of non-health sectors and provide support in identifying and engaging non-health sectors</p> <p>Collate and publish Member States' experiences</p>	<p>Advocate across sectors the added value of multisectoral work</p> <p>Provide financial and technical capacity to multisectoral activities (e.g. water and sanitation)</p> <p>Provide support to Member States in collecting and disseminating experiences</p>
3.2 Enhance effective international and national partnerships and alliances	<p>Promote active engagement in, and where appropriate, establish partnerships and alliances that harmonize and are aligned with national priorities, policies, plans and programmes</p> <p>Identify and promote suitable mechanisms for intercountry collaboration</p>	<p>Where appropriate, participate in and lead partnerships and alliances, including engaging other United Nations entities, that support, harmonize and are aligned with Member States' priorities, policies, plans and programmes</p> <p>Facilitate and support establishment of intercountry collaboration</p>	<p>Promote participation and actively support partnerships, alliances and intercountry collaboration that harmonize and are aligned with Member States' priorities, policies, plans and programmes</p>
3.3 Integrate eye health into poverty-reduction strategies, initiatives and wider socioeconomic policies	<p>Identify and incorporate eye health in relevant poverty-reduction strategies, initiatives and socioeconomic policies</p> <p>Ensure that people with avoidable and unavoidable visual impairment have access to educational opportunities, and that disability inclusion practices are developed, implemented and evaluated</p>	<p>Write and disseminate key messages for policy-makers</p> <p>Advise Member States on ways to include eye health/prevention of visual impairment in poverty-reduction strategies, initiatives and socioeconomic policies</p>	<p>Advocate the integration of eye health into poverty-reduction strategies, initiatives and socioeconomic policies</p>

APPENDIX 4

NATIONAL INDICATORS FOR PREVENTION OF AVOIDABLE BLINDNESS AND VISUAL IMPAIRMENT**1. Prevalence and causes of visual impairment**

Purpose/rationale	To measure the magnitude of visual impairment including blindness and monitor progress in eliminating avoidable blindness and in controlling avoidable visual impairment
Definition	Prevalence of visual impairment, including blindness, and its causes, preferably disaggregated by age and gender
Preferred methods of data collection	Methodologically sound and representative surveys of prevalence provide the most reliable method. Additionally, the Rapid Assessment of Avoidable Blindness and the Rapid Assessment of Cataract Surgical Services are two standard methodologies for obtaining results for people in the age group with the highest prevalence of visual impairment, that is, those over 50 years of age
Unit of measurement	Prevalence of visual impairment determined from population surveys
Frequency of data collection	At national level at least every five years
Source of data	Health ministry or national prevention of blindness/eye health coordinator/committee
Dissemination of data	The Secretariat periodically updates the global estimates on the prevalence and causes of visual impairment

2. Number of eye care personnel by cadre**2.1 Ophthalmologists**

Purpose/rationale	To assess availability of the eye health workforce in order to formulate a capacity–development response for strengthening national health systems. Ophthalmologists are the primary cadre that deliver medical and surgical eye care interventions
Definition	Number of medical doctors certified as ophthalmologists by national institutions based on government-approved certification criteria. Ophthalmologists are medical doctors who have been trained in ophthalmic medicine and/or surgery and who evaluate and treat diseases of the eye
Preferred methods of data collection	Registers of national professional and regulatory bodies

Unit of measurement	Number of ophthalmologists per one million population
Frequency of data collection	Annually
Limitations	The number does not reflect the proportion of ophthalmologists who are not surgically active; clinical output (e.g. subspecialists); performance; and quality of interventions. Unless disaggregated, the data do not reflect geographical distribution
Source of information	Health ministry or national prevention of blindness/eye health coordinator/committee
Dissemination of data	The Secretariat annually issues a global update based on the national data provided by Member States

2.2 Optometrists

Purpose/rationale	To assess availability of the eye health workforce in order to formulate a capacity-development response for strengthening national health systems. In an increasing number of countries, optometrists are often the first point of contact for persons with eye diseases
Definition	Number of optometrists certified by national institutions based on government-approved certification criteria
Preferred methods of data collection	Registers of national professional and regulatory bodies
Unit of measurement	Number of optometrists per one million population
Frequency of data collection	Annually
Limitations	The number does not denote performance, especially the quality of interventions to reduce avoidable blindness. There is a wide variability in knowledge and skill of optometrists from one nation to another because curricula are not standardized Numbers do not reflect the proportion of ophthalmic clinical officers, refractionists and other such groups who in some countries perform the role of optometrists where this cadre is short staffed or does not exist
Source of information	Health ministry or national prevention of blindness/eye health coordinator/committee
Dissemination of data	The Secretariat annually issues a global update based on the national data provided by Member States

2.3 Allied ophthalmic personnel

Purpose/rationale	To assess availability of the eye health workforce in order to formulate a capacity-development response for strengthening national health systems. Allied ophthalmic personnel may be characterized by different educational requirements, legislation and practice regulations, skills and scope of practice between countries and even within a given country. Typically, allied ophthalmic personnel comprise opticians, ophthalmic nurses, orthoptists, ophthalmic and optometric assistants, ophthalmic and optometric technicians, vision therapists, ocularists, ophthalmic photographer/imagers, and ophthalmic administrators
Definition	Numbers of allied ophthalmic personnel comprising professional categories, which need to be specified by a reporting Member State
Preferred methods of data collection	Compilation of national data from subnational (district) data from government, nongovernmental and private eye care service providers
Unit of measurement	Number of allied ophthalmic personnel per one million population
Frequency of data collection	Annually
Limitations	The numbers do not denote performance, especially the quality of interventions to reduce avoidable blindness. There is a wide variability in knowledge and skill. These data are useful for monitoring of progress in countries over time but they cannot be reliably used for intercountry comparison because of variation in nomenclature
Source of information	Health ministry or national prevention of blindness/eye health coordinator/committee
Dissemination of data	The Secretariat annually issues a global update based on the national data provided by Member States

3. Cataract surgical service delivery

3.1 Cataract surgical rate

Purpose/rationale	The rate can be used to set national targets for cataract surgical service delivery. It is also often used as a proxy indicator for general eye care service delivery. Globally, cataract remains the leading cause of blindness. Visual impairment and blindness from cataracts are avoidable because an effective means of treatment (cataract extraction with implantation of an intraocular lens) is both safe and efficacious to restore sight. The cataract surgical rate is a quantifiable measure of cataract surgical service delivery.
Definition	The number of cataract operations performed per year per one million population
Preferred methods of data collection	Government health information records, surveys

Unit of measurement	Number of cataract operations performed per one million population
Frequency of data collection	Annually at national level. In larger countries it is desirable to collate data at subnational level
Limitations	This indicator is meaningful only when it includes all cataract surgeries performed in a country, that is, those performed within the government and nongovernmental sectors
Comments	For calculations, use official sources of population data (United Nations)
Source of information	Health ministry or national prevention of blindness/eye health coordinator/committee
Dissemination of data	The Secretariat annually issues a global update based on the national data provided by Member States

3.2 Cataract surgical coverage

Purpose/rationale	To assess the degree to which cataract surgical services are meeting the need
Definition	Proportion of people with bilateral cataract eligible for cataract surgery who have received cataract surgery in one or both eyes (at 3/60 and 6/18 level)
Preferred methods of data collection	Calculation using data from methodologically sound and representative prevalence surveys. Additionally, calculation using data from the Rapid Assessment of Avoidable Blindness and the Rapid Assessment of Cataract Surgical Services, which are two standard methodologies to obtain results for people in the age group with the highest prevalence of blindness and visual impairment due to cataract, that is, those over 50 years of age
Unit of measurement	Proportion
Frequency of data collection	Determined by the frequency of performing a national/district study on the prevalence of blindness and visual impairment and their causes
Limitations	Requires population-based studies, which may be of limited generalization
Comments	Preferably data are disaggregated by gender, age, and urban/rural location or district
Source of information	Health ministry or national prevention of blindness/eye health coordinator/committee
Dissemination of data	The Secretariat periodically issues updates

ANNEX 3

Comprehensive mental health action plan 2013–2020¹

[A66/10 Rev.1 – 16 May 2013]

1. In May 2012, the Sixty-fifth World Health Assembly adopted resolution WHA65.4 on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level. It requested the Director-General, inter alia, to develop a comprehensive mental health action plan, in consultation with Member States, covering services, policies, legislation, plans, strategies and programmes.
2. This comprehensive action plan has been elaborated through consultations with Member States, civil society and international partners. It takes a comprehensive and multisectoral approach, through coordinated services from the health and social sectors, with an emphasis on promotion, prevention, treatment, rehabilitation, care and recovery. It also sets out clear actions for Member States, the Secretariat and international, regional and national level partners, and proposes key indicators and targets that can be used to evaluate levels of implementation, progress and impact. The action plan has, at its core, the globally accepted principle that there is “no health without mental health”.²
3. The action plan has close conceptual and strategic links to other global action plans and strategies endorsed by the Health Assembly, including the global strategy to reduce the harmful use of alcohol, the global plan of action for workers’ health, 2008–2017, the action plan for the global strategy for the prevention and control of noncommunicable diseases, 2008–2013, and the global action plan for the prevention and control of noncommunicable diseases (2013–2020). It also draws on WHO’s regional action plans and strategies for mental health and substance abuse that have been adopted or are being developed. The action plan has been designed to create synergy with other relevant programmes of organizations in the United Nations system, United Nations interagency groups and intergovernmental organizations.
4. The action plan builds upon, but does not duplicate, the work of WHO’s mental health gap action programme (mhGAP). The focus of the latter was to expand services for mental health in low-resource settings. The action plan is global in its scope and is designed to provide guidance for national action plans. It addresses, for all resource settings, the response of social and other relevant sectors, as well as promotion and prevention strategies.
5. In this action plan, the term “mental disorders” is used to denote a range of mental and behavioural disorders that fall within the International Statistical Classification of Diseases and Related Health Problems, Tenth revision (ICD-10). These include disorders that cause a high burden of disease such as depression, bipolar affective disorder, schizophrenia, anxiety disorders, dementia, substance use disorders, intellectual disabilities, and developmental and behavioural disorders with onset usually occurring in childhood and adolescence, including autism. For dementia and substance use disorders, additional prevention strategies may also be required (as described, for example, in a

¹ See resolution WHA66.8.

² The WHO web site provides a glossary of main terms; links to other global action plans, strategies and programmes; international and regional human rights treaties; and selected WHO technical materials and resources on mental health.

WHO report on dementia issued in early 2012¹ and in the global strategy to reduce the harmful use of alcohol). Furthermore, the plan covers suicide prevention and many of the actions are also relevant to conditions such as epilepsy. The term “vulnerable groups” is used in the action plan to refer to individuals or groups of individuals who are made vulnerable by the situations and environments that they are exposed to (as opposed to any inherent weakness or lack of capacity). The term “vulnerable groups” should be applied within countries as appropriate to the national situation.

6. The action plan also covers mental health, which is conceptualized as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. With respect to children, an emphasis is placed on the developmental aspects, for instance, having a positive sense of identity, the ability to manage thoughts, emotions, as well as to build social relationships, and the aptitude to learn and to acquire an education, ultimately enabling their full active participation in society.

7. In the light of widespread human rights violations and discrimination experienced by people with mental disorders, a human rights perspective is essential in responding to the global burden of mental disorders. The action plan emphasizes the need for services, policies, legislation, plans, strategies and programmes to protect, promote and respect the rights of persons with mental disorders in line with the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of Persons with Disabilities, the Convention on the Rights of the Child and other relevant international and regional human rights instruments.

OVERVIEW OF THE GLOBAL SITUATION

8. Mental health is an integral part of health and well-being, as reflected in the definition of health in the Constitution of the World Health Organization: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Mental health, like other aspects of health, can be affected by a range of socioeconomic factors (described below) that need to be addressed through comprehensive strategies for promotion, prevention, treatment and recovery in a whole-of-government approach.

Mental health and disorders: determinants and consequences

9. Determinants of mental health and mental disorders include not only individual attributes such as the ability to manage one’s thoughts, emotions, behaviours and interactions with others, but also social, cultural, economic, political and environmental factors such as national policies, social protection, living standards, working conditions, and community social supports. Exposure to adversity at a young age is an established preventable risk factor for mental disorders.

10. Depending on the local context, certain individuals and groups in society may be placed at a significantly higher risk of experiencing mental health problems. These vulnerable groups may (but do not necessarily) include members of households living in poverty, people with chronic health conditions, infants and children exposed to maltreatment and neglect, adolescents first exposed to substance use, minority groups, indigenous populations, older people, people experiencing discrimination and human rights violations, lesbian, gay, bisexual, and transgender persons, prisoners, and people exposed to conflict, natural disasters or other humanitarian emergencies. The current global financial crisis provides a powerful example of a macroeconomic factor leading to cuts in funding despite a concomitant need for more mental health and social services because of higher rates

¹ Alzheimer’s Disease International. *Dementia: a public health priority*. Geneva: World Health Organization; 2012.

of mental disorders and suicide as well as the emergence of new vulnerable groups (for example, the young unemployed). In many societies, mental disorders related to marginalization and impoverishment, domestic violence and abuse, and overwork and stress are of growing concern, especially for women's health.

11. People with mental disorders experience disproportionately higher rates of disability and mortality. For example, persons with major depression and schizophrenia have a 40% to 60% greater chance of dying prematurely than the general population, owing to physical health problems that are often left unattended (such as cancers, cardiovascular diseases, diabetes and HIV infection) and suicide. Suicide is the second most common cause of death among young people worldwide.

12. Mental disorders often affect, and are affected by, other diseases such as cancer, cardiovascular disease and HIV infection/AIDS, and as such require common services and resource mobilization efforts. For example, there is evidence that depression predisposes people to myocardial infarction and diabetes, both of which conversely increase the likelihood of depression. Many risk factors such as low socioeconomic status, alcohol use and stress are common to both mental disorders and other noncommunicable diseases. There is also substantial concurrence of mental disorders and substance use disorders. Taken together, mental, neurological and substance use disorders exact a high toll, accounting for 13% of the total global burden of disease in the year 2004. Depression alone accounts for 4.3% of the global burden of disease and is among the largest single causes of disability worldwide (11% of all years lived with disability globally), particularly for women. The economic consequences of these health losses are equally large: a recent study estimated that the cumulative global impact of mental disorders in terms of lost economic output will amount to US\$ 16.3 billion between 2011 and 2030.¹

13. Mental disorders frequently lead individuals and families into poverty.² Homelessness and inappropriate incarceration are far more common for people with mental disorders than for the general population, and exacerbate their marginalization and vulnerability. Because of stigmatization and discrimination, persons with mental disorders often have their human rights violated and many are denied economic, social and cultural rights, with restrictions on the rights to work and education, as well as reproductive rights and the right to the highest attainable standard of health. They may also be subject to unhygienic and inhuman living conditions, physical and sexual abuse, neglect, and harmful and degrading treatment practices in health facilities. They are often denied civil and political rights such as the right to marry and found a family, personal liberty, the right to vote and to participate effectively and fully in public life, and the right to exercise their legal capacity on other issues affecting them, including their treatment and care. As such, persons with mental disorders often live in vulnerable situations and may be excluded and marginalized from society, which constitutes a significant impediment to the achievement of national and international development goals. The Convention on the Rights of Persons with Disabilities, which is binding on States Parties that have ratified or acceded to it, protects and promotes the rights of all persons with disabilities, including persons with mental and intellectual impairments, and also promotes their full inclusion in international cooperation including international development programmes.

¹ World Economic Forum, the Harvard School of Public Health. *The global economic burden of non-communicable diseases*. Geneva, World Economic Forum, 2011.

² *Mental health and development: targeting people with mental health conditions as a vulnerable group*. Geneva, World Health Organization, 2010.

Health system resources and responses

14. Health systems have not yet adequately responded to the burden of mental disorders; as a consequence, the gap between the need for treatment and its provision is large all over the world. Between 76% and 85% of people with severe mental disorders receive no treatment for their disorder in low-income and middle-income countries; the corresponding range for high-income countries is also high: between 35% and 50%. A further compounding problem is the poor quality of care for those receiving treatment. WHO's *Mental Health Atlas 2011* provides data that demonstrate the scarcity of resources within countries to meet mental health needs, and underlines the inequitable distribution and inefficient use of such resources. Globally, for instance, annual spending on mental health is less than US\$ 2 per person and less than US\$ 0.25 per person in low-income countries, with 67% of these financial resources allocated to stand-alone mental hospitals, despite their association with poor health outcomes and human rights violations. Redirecting this funding towards community-based services, including the integration of mental health into general health care settings, and through maternal, sexual, reproductive and child health, HIV/AIDS and chronic noncommunicable disease programmes, would allow access to better and more cost-effective interventions for many more people.

15. The number of specialized and general health workers dealing with mental health in low-income and middle-income countries is grossly insufficient. Almost half the world's population lives in countries where, on average, there is one psychiatrist to serve 200 000 or more people; other mental health care providers who are trained in the use of psychosocial interventions are even scarcer. Similarly, a much higher proportion of high-income countries than low-income countries reports having a policy, plan and legislation on mental health; for instance, only 36% of people living in low-income countries are covered by mental health legislation compared with 92% in high-income countries.

16. Civil society movements for mental health in low-income and middle-income countries are not well developed. Organizations of people with mental disorders and psychosocial disabilities are present in only 49% of low-income countries compared with 83% of high-income countries; for family associations the respective figures are 39% and 80%.

17. Finally, the availability of basic medicines for mental disorders in primary health care is notably low (in comparison to medicines available for infectious diseases and even other noncommunicable diseases), and their use restricted because of the lack of qualified health workers with the appropriate authority to prescribe medications. In addition, the availability of non-pharmacological approaches and trained personnel to deliver these interventions is also lacking. Such factors act as important barriers to appropriate care for many persons with mental disorders.

18. To improve the situation, and in addition to the data on mental health resources in countries (from WHO's *Mental Health Atlas 2011*, as well as the more detailed profiling obtained through use of WHO's assessment instrument for mental health systems),¹ information is available on cost-effective and feasible mental health interventions that can be expanded to a larger scale to strengthen mental health care systems in countries. WHO's Mental Health Gap Action Programme, launched in 2008, uses evidence-based technical guidance, tools and training packages to expand service provision in countries, especially in resource-poor settings. It focuses on a prioritized set of conditions and, importantly, directs its capacity building towards non-specialized health care providers in an integrated approach that promotes mental health at all levels of care.

¹ WHO-AIMS version 2.2: World Health Organization assessment instrument for mental health systems, Geneva, World Health Organization, 2005 (document WHO/MSD/MER/05.2).

19. The Secretariat has elaborated other technical tools and guidance in support of countries in developing comprehensive mental health policies, plans and laws that promote improved quality and availability of mental health care (such as the WHO mental health policy and service guidance package);¹ in improving quality and respecting the rights of persons with mental disorders in health services (the WHO QualityRights toolkit);² and for disaster relief and post-disaster mental health system reconstruction (including the Inter-Agency Standing Committee Guidelines in mental health and psychosocial support in emergency settings).³ Knowledge, information and technical tools are necessary but not sufficient; strong leadership, enhanced partnerships and the commitment of resources towards implementation are also required in order to move decisively from evidence to action and evaluation.

STRUCTURE OF THE COMPREHENSIVE ACTION PLAN 2013–2020

20. The **vision** of the action plan is a world in which mental health is valued, promoted and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high quality, culturally-appropriate health and social care in a timely way to promote recovery, in order to attain the highest possible level of health and participate fully in society and at work, free from stigmatization and discrimination.

21. Its overall **goal** is to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders.

22. The action plan has the following **objectives**:

- (1) to strengthen effective leadership and governance for mental health;
- (2) to provide comprehensive, integrated and responsive mental health and social care services in community-based settings;
- (3) to implement strategies for promotion and prevention in mental health;
- (4) to strengthen information systems, evidence and research for mental health.

The global targets established for each objective provide the basis for measurable collective action and achievement by Member States towards global goals and should not negate the setting of more ambitious national targets, particularly for those countries that have already reached global ones. Indicators for measuring progress towards defined global targets are provided in Appendix 1.

23. The action plan relies on six **cross-cutting principles and approaches**:

- *Universal health coverage*: Regardless of age, sex, socioeconomic status, race, ethnicity or sexual orientation, and following the principle of equity, persons with mental disorders should

¹ http://www.who.int/mental_health/policy/essentialpackage1/en/index.html (accessed 24 May 2013).

² *WHO QualityRights tool kit: assessing and improving quality and human rights in mental health and social care facilities*. Geneva, World Health Organization, 2012.

³ Inter-Agency Standing Committee. *IASC guidelines on mental health and psychosocial support in emergency settings*. Geneva, Inter-Agency Standing Committee, 2007.

be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health.

- *Human rights*: Mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.
- *Evidence-based practice*: Mental health strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and/or best practice, taking cultural considerations into account.
- *Life course approach*: Policies, plans and services for mental health need to take account of health and social needs at all stages of the life course, including infancy, childhood, adolescence, adulthood and older age.
- *Multisectoral approach*: A comprehensive and coordinated response for mental health requires partnership with multiple public sectors such as health, education, employment, judicial, housing, social and other relevant sectors as well as the private sector, as appropriate to the country situation.
- *Empowerment of persons with mental disorders and psychosocial disabilities*: Persons with mental disorders and psychosocial disabilities should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation.

24. The framework provided in this action plan needs to be adapted at regional level in order to take into account region-specific situations. The actions proposed for Member States are to be considered and adapted, as appropriate, to national priorities and specific national circumstances in order to accomplish the objectives. There is no blueprint action plan that fits all countries, as countries are at different stages in developing and implementing a comprehensive response in the area of mental health.

PROPOSED ACTIONS FOR MEMBER STATES AND INTERNATIONAL AND NATIONAL PARTNERS AND ACTIONS FOR THE SECRETARIAT

25. To achieve the plan's stated vision, goal and objectives, specific actions are proposed for Member States and for international and national partners. In addition, actions for the Secretariat have been identified. Although actions are specified separately for each objective, many of these will also contribute to the attainment of the other objectives of the action plan. Some possible options to implement these actions are proposed in Appendix 2.

26. Effective implementation of the global mental health action plan will require actions by international, regional and national partners. These partners include but are not limited to:

- development agencies including international multilateral agencies (for example, the World Bank and United Nations development agencies), regional agencies (for example, regional development banks), subregional intergovernmental agencies and bilateral development aid agencies;
- academic and research institutions including the network of WHO collaborating centres for mental health, human rights and social determinants of health and other related networks, within developing and developed countries;

- civil society, including organizations of persons with mental disorders and psychosocial disabilities, service-user and other similar associations and organizations, family member and carer associations, mental health and other related nongovernmental organizations, community-based organizations, human rights-based organizations, faith-based organizations, development and mental health networks and associations of health care professionals and service providers.

27. The roles of these three groups are often overlapping and can include multiple actions across the areas of governance, health and social care services, promotion and prevention in mental health, and information, evidence and research (see actions listed below). Country-based assessments of the needs and capacity of different partners will be essential to clarify the roles and actions of key stakeholder groups.

Objective 1: To strengthen effective leadership and governance for mental health

28. Planning, organizing and financing health systems is a complex undertaking involving multiple stakeholders and different administrative levels. As the ultimate guardian of a population's mental health, governments have the lead responsibility to put in place appropriate institutional, legal, financing and service arrangements to ensure that needs are met and the mental health of the whole population is promoted.

29. Governance is not just about government, but extends to its relationship with nongovernmental organizations and civil society. A strong civil society, particularly organizations of people with mental disorders and psychosocial disabilities and families and carers, can help to create more effective and accountable policies, laws and services for mental health in a manner consistent with international and regional human rights instruments.

30. Among the key factors for developing effective policies and plans addressing mental health are strong leadership and commitment by governments, involvement of relevant stakeholders, clear elaboration of areas for action, formulation of financially-informed and evidence-based actions, explicit attention to equity, respect for the inherent dignity and human rights of people with mental disorders and psychosocial disabilities, and the protection of vulnerable and marginalized groups.

31. Responses will be stronger and more effective when mental health interventions are firmly integrated within the national health policy and plan. In addition, often it is necessary to develop a dedicated mental health policy and plan in order to provide more detailed direction.

32. Mental health law, whether an independent legislative document or integrated into other health and capacity-related laws, should codify the key principles, values and objectives of policy for mental health, for example by establishing legal and oversight mechanisms to promote human rights and the development of accessible health and social services in the community.

33. Policies, plans and laws for mental health should comply with obligations under the Convention on the Rights of Persons with Disabilities and other international and regional human rights conventions.

34. The inclusion and mainstreaming of mental health issues more explicitly within other priority health programmes and partnerships (for instance, HIV/AIDS, women's and children's health, noncommunicable diseases and the global health workforce alliance), as well as within other relevant sectors' policies and laws, for example, those dealing with education, employment, disability, the judicial system, human rights protection, social protection, poverty reduction and development, are important means of meeting the multidimensional requirements of mental health systems and should

remain central to leadership efforts of governments to improve treatment services, prevent mental disorders and promote mental health.

Global target 1.1: 80% of countries will have developed or updated their policies/plans for mental health in line with international and regional human rights instruments (by the year 2020).

Global target 1.2: 50% of countries will have developed or updated their laws for mental health in line with international and regional human rights instruments (by the year 2020).

Proposed actions for Member States

35. *Policy and law:* Develop, strengthen, keep up to date and implement national policies, strategies, programmes, laws and regulations relating to mental health within all relevant sectors, including codes of practice and mechanisms to monitor protection of human rights and implementation of legislation, in line with evidence, best practice, the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.

36. *Resource planning:* Plan according to measured need and allocate a budget across all relevant sectors that is commensurate with identified human and other resources required to implement agreed-upon evidence-based mental health plans and actions.

37. *Stakeholder collaboration:* Motivate and engage stakeholders from all relevant sectors, including persons with mental disorders, carers and family members, in the development and implementation of policies, laws and services relating to mental health, through a formalized structure and/or mechanism.

38. *Strengthening and empowerment of people with mental disorders and psychosocial disabilities and their organizations:* Ensure that people with mental disorders and psychosocial disabilities are given a formal role and authority to influence the process of designing, planning and implementing policies, laws and services.

Actions for the Secretariat

39. *Policy and law:* Compile knowledge and best practices for – and build capacity in – the development, multisectoral implementation and evaluation of policies, plans and laws relevant to mental health, including codes of practice and mechanisms to monitor protection of human rights and implementation of legislation, in line with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.

40. *Resource planning:* Offer technical support to countries in multisectoral resource planning, budgeting and expenditure tracking for mental health.

41. *Stakeholder collaboration:* Provide best practices and tools to strengthen collaboration and interaction at international, regional and national levels between the stakeholders in the development, implementation and evaluation of policy, strategies, programmes and laws for mental health, including the health, judicial and social sectors, civil society groups, persons with mental disorders and psychosocial disabilities, carers and family members, and organizations in the United Nations system and human rights agencies.

42. *Strengthening and empowerment of people with mental disorders and psychosocial disabilities and their organizations:* Engage organizations of people with mental disorders and psychosocial disabilities in policy making at international, regional and national levels within WHO's own structures

and provide support to organizations to design technical tools for capacity building, based on international and regional human rights instruments and WHO's own human rights and mental health tools.

Proposed actions for international and national partners

43. Mainstream mental health interventions into health, poverty reduction, development policies, strategies and interventions.
44. Include people with mental disorders as a vulnerable and marginalized group requiring prioritized attention and engagement within development and poverty-reduction strategies, for example, in education, employment and livelihood programmes, and the human rights agenda.
45. Explicitly include mental health within general and priority health policies, plans and research agenda, including noncommunicable diseases, HIV/AIDS, women's health, child and adolescent health, as well as through horizontal programmes and partnerships, such as the Global Health Workforce Alliance, and other international and regional partnerships.
46. Support opportunities for exchange between countries on effective policy, legislative and intervention strategies for promoting mental health, preventing mental disorders and promoting recovery from disorders based on the international and regional human rights framework.
47. Support the creation and strengthening of associations and organizations of people with mental disorders and psychosocial disabilities as well as families and carers, and their integration into existing disability organizations, and facilitate dialogue between these groups, health workers and government authorities in health, human rights, disability, education, employment, the judiciary and social sectors.

Objective 2: To provide comprehensive, integrated and responsive mental health and social care services in community-based settings

48. In the context of improving access to care and service quality, WHO recommends the development of comprehensive community-based mental health and social care services; the integration of mental health care and treatment into general hospitals and primary care; continuity of care between different providers and levels of the health system; effective collaboration between formal and informal care providers; and the promotion of self-care, for instance, through the use of electronic and mobile health technologies.
49. Developing mental health services of good quality requires the use of evidence-based protocols and practices, including early intervention, incorporation of human rights principles, respect for individual autonomy and the protection of people's dignity. Furthermore, health workers must not limit intervention to improving mental health but also attend to the physical health care needs of children, adolescents and adults with mental disorders, and vice versa, because of the high rates of co-morbid physical and mental health problems and associated risk factors, for example, high rates of tobacco consumption, that go unaddressed.
50. Community-based service delivery for mental health needs to encompass a recovery-based approach that puts the emphasis on supporting individuals with mental disorders and psychosocial disabilities to achieve their own aspirations and goals. The core service requirements include: listening and responding to individuals' understanding of their condition and what helps them to recover; working with people as equal partners in their care; offering choice of treatment and therapies, and in terms of who provides care; and the use of peer workers and supports, who provide each other with encouragement and a sense of belonging, in addition to their expertise. In addition, a multisectoral approach is required whereby services support individuals, at different stages of the life course and, as

appropriate, facilitate their access to human rights such as employment (including return-to-work programmes), housing and educational opportunities, and participation in community activities, programmes and meaningful activities.

51. More active involvement and support of service users in the reorganization, delivery and evaluation and monitoring of services is required so that care and treatment become more responsive to their needs. Greater collaboration with “informal” mental health care providers, including families, as well as religious leaders, faith healers, traditional healers, school teachers, police officers and local nongovernmental organizations, is also needed.

52. Another essential requirement is for services to be responsive to the needs of vulnerable and marginalized groups in society, including socioeconomically disadvantaged families, people living with HIV/AIDS, women and children living with domestic violence, survivors of violence, lesbian, gay, bisexual and transgendered people, indigenous peoples, immigrants, asylum seekers, persons deprived of liberty, and minority groups among others within the national context.

53. When planning for humanitarian emergency response and recovery, it is crucial to ensure that mental health services and community psychosocial supports are widely available.

54. Exposure to adverse life events or extreme stressors, such as natural disasters, isolated, repeated or continuing conflict and civil unrest or ongoing family and domestic violence, may have serious health and mental health consequences that require careful examination, particularly with regard to issues of diagnostic characterization (especially avoiding over-diagnosis and over-medicalization) and approaches to support, care and rehabilitation.

55. Having the right number and equitable distribution of competent, sensitive and appropriately skilled health professionals and workers is central to the expansion of services for mental health and the achievement of better outcomes. Integrating mental health into general health, disease-specific and social care services and programmes (such as those on women’s health and HIV/AIDS) provides an important opportunity to manage mental health problems better, promote mental health and prevent mental disorders. For example, health workers trained in mental health should be equipped not only to manage mental disorders in the persons they see, but also to provide general wellness information and screening for related health conditions, including noncommunicable diseases and substance use. Not only does service integration require the acquisition of new knowledge and skills to identify, manage and refer people with mental disorders as appropriate, but also the re-definition of health workers’ roles and changes to the existing service culture and attitudes of general health workers, social workers, occupational therapists and other professional groups. Furthermore, in this context, the role of specialized mental health professionals needs to be expanded to encompass supervision and support of general health workers in providing mental health interventions.

Global target 2: Service coverage for severe mental disorders will have increased by 20% (by the year 2020).

Proposed actions for Member States

56. *Service reorganization and expanded coverage:* Systematically shift the locus of care away from long-stay mental hospitals towards non-specialized health settings with increasing coverage of evidence-based interventions (including the use of stepped care principles, as appropriate) for priority conditions and using a network of linked community-based mental health services, including short-stay inpatient care, and outpatient care in general hospitals, primary care, comprehensive mental health centres, day care centres, support of people with mental disorders living with their families, and supported housing.

57. *Integrated and responsive care*: Integrate and coordinate holistic prevention, promotion, rehabilitation, care and support that aims at meeting both mental and physical health care needs and facilitates the recovery of persons of all ages with mental disorders within and across general health and social services (including the promotion of the right to employment, housing, and education) through service user-driven treatment and recovery plans and, where appropriate, with the inputs of families and carers.

58. *Mental health in humanitarian emergencies* (including isolated, repeated or continuing conflict, violence and disasters): Work with national emergency committees and mental health providers in order to include mental health and psychosocial support needs in emergency preparedness and enable access to safe and supportive services, including services that address psychological trauma and promote recovery and resilience, for persons with mental disorders (pre-existing as well as emergency-induced) or psychosocial problems, including services for health and humanitarian workers, during and following emergencies, with due attention to the longer-term funding required to build or rebuild a community-based mental health system after the emergency.

59. *Human resource development*: Build the knowledge and skills of general and specialized health workers to deliver evidence-based, culturally appropriate and human rights-oriented mental health and social care services, for children and adolescents, inter alia, by introducing mental health into undergraduate and graduate curricula; and through training and mentoring health workers in the field, particularly in non-specialized settings, in order to identify people with mental disorders and offer appropriate treatment and support as well as to refer people, as appropriate, to other levels of care.

60. *Address disparities*: Proactively identify and provide appropriate support for groups at particular risk of mental illness who have poor access to services.

Actions for the Secretariat

61. *Service reorganization and expanded coverage*: Provide guidance and evidence-based practices for deinstitutionalization and service reorganization, and provide technical support for expanding treatment and support, prevention and mental health promotion through recovery-oriented community-based mental health and social support services.

62. *Integrated and responsive care*: Collate and disseminate evidence and best practices for the integration and multisectoral coordination of holistic care, emphasizing recovery and support needs for persons with mental disorders, including alternatives to coercive practices and strategies to engage service users, families and carers in service planning and treatment decisions, and provide examples of financing mechanisms to facilitate multisectoral collaboration.

63. *Mental health in humanitarian emergencies* (including isolated, repeated or continuing conflict, violence, and disasters): Provide technical advice and guidance for policy and field activities related to mental health undertaken by governmental, nongovernmental and intergovernmental organizations, including the building or rebuilding after an emergency of a community-based mental health system that is sensitive to trauma-related issues.

64. *Human resource development*: Support countries in the formulation of a human resource strategy for mental health, including the identification of gaps, specification of needs, training requirements and core competencies for health workers in the field, as well as for undergraduate and graduate educational curricula.

65. *Address disparities*: Collect and disseminate evidence and best practices for reducing mental health and social service gaps for marginalized groups.

Proposed actions for international and national partners

66. Use funds received for direct service delivery to provide community-based mental health care rather than institutional care.
67. Assist the training of health workers in skills to identify mental disorders and provide evidence-based and culturally-appropriate interventions to promote the recovery of people with mental disorders.
68. Support coordinated efforts to implement mental health programmes during and after humanitarian emergency situations, including the training and capacity building of health and social service workers.

Objective 3: To implement strategies for promotion and prevention in mental health

69. In the context of national efforts to develop and implement health policies and programmes, it is vital to meet not only the needs of persons with defined mental disorders, but also to protect and promote the mental well-being of all citizens. Mental health evolves throughout the life-cycle. Therefore, governments have an important role in using information on risk and protective factors for mental health to put in place actions to prevent mental disorders and to protect and promote mental health at all stages of life. The early stages of life present a particularly important opportunity to promote mental health and prevent mental disorders, as up to 50% of mental disorders in adults begin before the age of 14 years. Children and adolescents with mental disorders should be provided with early intervention through evidence-based psychosocial and other non-pharmacological interventions based in the community, avoiding institutionalization and medicalization. Furthermore, interventions should respect the rights of children in line with the United Nations Convention on the Rights of the Child and other international and regional human rights instruments.
70. Responsibility for promoting mental health and preventing mental disorders extends across all sectors and all government departments. This is because poor mental health is strongly influenced by a range of social and economic determinants including income level, employment status, education level, material standard of living, physical health status, family cohesion, discrimination, violations of human rights and exposure to adverse life events, including sexual violence, child abuse and neglect. Mental health needs of children and adolescents who are exposed to natural disasters or civil conflict and unrest, including those who have been associated with armed forces or armed groups, are very high and require special attention.
71. Broad strategies for mental health promotion and the prevention of mental disorders across the life course may focus on: antidiscrimination laws and information campaigns that redress the stigmatization and human rights violations all too commonly associated with mental disorders; promotion of the rights, opportunities and care of individuals with mental disorders; the nurturing of core individual attributes in the formative stages of life (such as early childhood programmes, life skills and sexuality education, programmes to support the development of safe, stable and nurturing relationships between children, their parents and carers); early intervention through identification, prevention and treatment of emotional or behavioural problems, especially in childhood and adolescence; provision of healthy living and working conditions (including work organizational improvements and evidence-based stress management schemes in the public as well as the private

sector); protection programmes or community protection networks that tackle child abuse as well as other violence at domestic and community levels and social protection for the poor.¹

72. Suicide prevention is an important priority. Many people who attempt suicide come from vulnerable and marginalized groups. Moreover, young people and the elderly are among the most susceptible age groups to suicidal ideation and self-harm. Suicide rates tend to be underreported owing to weak surveillance systems, a misattribution of suicide to accidental deaths, as well as its criminalization in some countries. Nevertheless, most countries are showing either a stable or an increasing trend in the rate of suicide, while several others are showing long-term decreasing trends. As there are many risk factors associated with suicide beyond mental disorder, such as chronic pain or acute emotional distress, actions to prevent suicide must not only come from the health sector, but also from other sectors simultaneously. Reducing access to means to cause self-harm or commit suicide (including firearms, pesticides and availability of toxic medicines that can be used in overdoses), responsible reporting by the media, protecting persons at high risk of suicide, and early identification and management of mental disorder and of suicidal behaviours can be effective.

Global target 3.1: 80% of countries will have at least two functioning national, multisectoral promotion and prevention programmes in mental health (by the year 2020).

Global target 3.2: The rate of suicide in countries will be reduced by 10% (by the year 2020).

Proposed actions for Member States

73. *Mental health promotion and prevention:* Lead and coordinate a multisectoral strategy that combines universal and targeted interventions for: promoting mental health and preventing mental disorders; reducing stigmatization, discrimination and human rights violations; and which is responsive to specific vulnerable groups across the lifespan and integrated within the national mental health and health promotion strategies.

74. *Suicide prevention:* Develop and implement comprehensive national strategies for the prevention of suicide, with special attention to groups identified as at increased risk of suicide, including lesbian, gay, bisexual and transgender persons, youth and other vulnerable groups of all ages based on local context.

Actions for the Secretariat

75. *Mental health promotion and prevention:* Provide technical support to countries on the selection, formulation and implementation of evidence-based and cost-effective best practices for promoting mental health, preventing mental disorders, reducing stigmatization and discrimination, and promoting human rights across the lifespan.

76. *Suicide prevention:* Provide technical support to countries in strengthening their suicide prevention programmes with special attention to groups identified as at increased risk of suicide.

Proposed actions for international and national partners

77. Engage all stakeholders in advocacy to raise awareness of the magnitude of burden of disease associated with mental disorders and the availability of effective intervention strategies for the

¹ See *Risks to mental health: an overview of vulnerabilities and risk factors. Background paper by WHO Secretariat for the development of a comprehensive mental health action plan.*

promotion of mental health, prevention of mental disorders and treatment, care and recovery of persons with mental disorders.

78. Advocate the rights of persons with mental disorders and psychosocial disabilities to receive government disability benefits, gain access to housing and livelihood programmes, and, more broadly, to participate in work and community life and civic affairs.

79. Ensure that people with mental disorders and psychosocial disabilities are included in activities of the wider disability community, for example, when advocating for human rights and in processes for reporting on the implementation of the Convention on the Rights of Persons with Disabilities and other international and regional human rights conventions.

80. Introduce actions to combat stigmatization, discrimination and other human rights violations towards people with mental disorders and psychosocial disabilities.

81. Be partners in the development and implementation of all relevant programmes for mental health promotion and prevention of mental disorders.

Objective 4: To strengthen information systems, evidence and research for mental health

82. Information, evidence and research are critical ingredients for appropriate mental health policy, planning and evaluation. The generation of new knowledge through research enables policies and actions to be based on evidence and best practice, and the availability of timely and relevant information or surveillance frameworks enables implemented actions to be monitored and improvements in service provision to be detected. Currently, the research imbalance whereby most research is conducted in and by high-income countries needs to be corrected in order to ensure that low-income and middle-income countries have culturally appropriate and cost-effective strategies to respond to mental health needs and priorities.

83. Although summary mental health profiles are available through periodic assessments such as WHO's Project ATLAS, routine information systems for mental health in most low-income and middle-income countries are rudimentary or absent, making it difficult to understand the needs of local populations and to plan accordingly.

84. Crucial information and indicators that are needed for the mental health system include: the extent of the problem (the prevalence of mental disorders and identification of major risk factors and protective factors for mental health and well-being); coverage of policies and legislation, interventions and services (including the gap between the number of people who have a mental disorder and those who receive treatment and a range of appropriate services, such as social services); health outcome data (including suicide and premature mortality rates at the population level as well as individual- or group-level improvements related to clinical symptoms, levels of disability, overall functioning and quality of life) and social and economic outcome data (including relative levels of educational achievement, housing, employment and income among persons with mental disorders). These data need to be disaggregated by sex and age and reflect the diverse needs of subpopulations, including individuals from geographically diverse communities (for instance, urban versus rural), and vulnerable populations. Data will need to be collected through ad hoc periodic surveys in addition to the data collected through the routine health information system. Valuable opportunities also exist to draw on existing data, for example, gathering information from the reports submitted to treaty-monitoring bodies by governments and nongovernmental and other bodies as part of the periodic reporting mechanisms.

Global target 4: 80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems (by the year 2020).

Proposed actions for Member States

85. *Information systems:* Integrate mental health into the routine health information system and identify, collate, routinely report and use core mental health data disaggregated by sex and age (including data on completed and attempted suicides) in order to improve mental health service delivery, promotion and prevention strategies and to provide data for the Global Mental Health Observatory (as a part of WHO's Global Health Observatory).

86. *Evidence and research:* Improve research capacity and academic collaboration on national priorities for research in mental health, particularly operational research with direct relevance to service development and implementation and the exercise of human rights by persons with mental disorders, including the establishment of centres of excellence with clear standards, with the inputs of all relevant stakeholders including persons with mental disorders and psychosocial disabilities.

Actions for the Secretariat

87. *Information systems:* Develop a core set of mental health indicators and provide guidance, training and technical support on the development of surveillance/information systems to capture information for the core mental health indicators, facilitate the use of these data to monitor inequities and health outcomes, and augment the information collected by WHO's Global Mental Health Observatory (as a part of WHO's Global Health Observatory) by establishing baseline data to monitor the global mental health situation (including progress on reaching the targets laid out in this action plan).

88. *Evidence and research:* Engage relevant stakeholders, including people with mental disorders and psychosocial disabilities and their organizations, in the development and promotion of a global mental health research agenda, facilitate global networks for research collaboration, and carry out culturally validated research related to burden of disease, advances in mental health promotion, prevention, treatment, recovery, care, policy and service evaluation.

Proposed actions for international and national partners

89. Provide support to Member States to set up surveillance/information systems that: capture core indicators on mental health, health and social services for persons with mental disorders; enable an assessment of change over time; and provide an understanding of the social determinants of mental health problems.

90. Support research aimed at filling the gaps in knowledge about mental health, including the delivery of health and social services for persons with mental disorders and psychosocial disabilities.

APPENDIX 1

**INDICATORS FOR MEASURING PROGRESS TOWARDS DEFINED TARGETS
OF THE COMPREHENSIVE MENTAL HEALTH ACTION PLAN 2013–2020**

The indicators for assessing progress towards meeting the global targets of the comprehensive mental health action plan represent a subset of the information and reporting needs that Member States require to be able to monitor adequately their mental health policies and programmes. Given that targets are voluntary and global, each Member State is not necessarily expected to achieve all the specific targets but can contribute to a varying extent towards reaching them jointly. As indicated under Objective 4 of the plan, the Secretariat will provide guidance, training and technical support to Member States, upon request, on the development of national information systems for capturing data on indicators of mental health system inputs, activities and outcomes. The aim is to build on existing information systems rather than creating new or parallel systems. Baselines for each target will be established early during the implementation phase of the global action plan.

Objective 1: To strengthen effective leadership and governance for mental health

<i>Global target 1.1</i>	80% of countries will have developed or updated their policy/plan for mental health in line with international and regional human rights instruments (by the year 2020).
Indicator	Existence of a national policy and/or plan for mental health that is in line with international human rights instruments [<i>yes/no</i>].
Means of verification	Physical availability of the policy/plan and confirmation that it accords with international and regional human rights standards.
Comments/assumptions	Many policies and plans older than 10 years may not reflect recent developments in international human rights standards and evidence-based practice. For countries with a federated system, the indicator will refer to policies/plans of the majority of states/provinces within the country. Policies or plans for mental health may be stand-alone or integrated into other general health or disability policies or plans.

<i>Global target 1.2</i>	50% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments (by the year 2020).
Indicator	Existence of a national law covering mental health that is in line with international human rights instruments [<i>yes/no</i>].
Means of verification	Physical availability of the law and confirmation that it accords with international and regional human rights standards.
Comments/assumptions	Laws older than 10 years may not reflect recent developments in international human rights standards and evidence-based practice. For countries with a federated system, the indicator will refer to the laws of the majority of states/provinces within the country. Laws for mental health may be stand-alone or integrated into other general health or disability laws.

Objective 2: To provide comprehensive, integrated and responsive mental health and social care services in community-based settings

Global target 2	Service coverage for severe mental disorders will have increased by 20% (by the year 2020).
Indicator	Proportion of persons with a severe mental disorder (psychosis; bipolar affective disorder; moderate-severe depression) who are using services [%].
Means of verification	<i>Numerator:</i> Cases of severe mental disorder in receipt of services, derived from routine information systems or, if unavailable, a baseline and follow-up survey of health facilities in one or more defined geographical areas of a country. <i>Denominator:</i> Total cases of severe mental disorder in the sampled population, derived from national surveys or, if unavailable, subregional or global prevalence estimates.
Comments/assumptions	Estimates of service coverage are needed for all mental disorders, but are restricted here to severe mental disorders to limit measurement effort. Health facilities range from primary care centres to general and specialized hospitals; they may offer social care and support as well as psychosocial and/or pharmacological treatment on an outpatient or inpatient basis. To limit measurement effort, and where needed, countries may restrict the survey to hospital-based and overnight facilities only (with some loss of accuracy, due to omission of primary care and other service providers). The baseline survey will be undertaken in 2014, with follow-up at 2020 (and preferably also at mid-point in 2017); the survey questionnaire can be supplemented in order also to investigate service readiness and quality, as desired. The Secretariat can provide guidance and technical support to Member States regarding survey design and instrumentation.

Objective 3: To implement strategies for promotion and prevention in mental health

Global target 3.1	80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes (by the year 2020).
Indicator	Functioning programmes of multisectoral mental health promotion and prevention in existence [yes/no].
Means of verification	Inventory or project-by-project description of currently implemented programmes.
Comments/assumptions	Programmes may – and preferably should – cover both universal, population-level promotion or prevention strategies (e.g. mass media campaigns against discrimination) and those aimed at locally identified vulnerable groups (e.g. children exposed to adverse life events).

Global target 3.2	The rate of suicide in countries will be reduced by 10% (by the year 2020).
Indicator	Number of suicide deaths per year per 100 000 population.
Means of verification	Routine annual registration of deaths due to suicide (baseline year: 2012 or 2013).
Comments/assumptions	Effective action towards this target requires joint action from multiple sectors outside health/mental health sector. Obtaining accurate surveillance data is difficult and owing to more accurate reporting of suicides, population ageing and other possible factors, total recorded suicides may not decrease in some countries; however, the rate of suicide (as opposed to total suicides) best reflects improved prevention efforts.

Objective 4: To strengthen information systems, evidence and research for mental health

Global target 4	80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems (by the year 2020).
Indicator	Core set of identified and agreed mental health indicators routinely collected and reported every two years <i>[yes/no]</i> .
Means of verification	Reporting and submission of core mental health indicator set to WHO every two years.
Comments/assumptions	Core mental health indicators include those relating to specified targets of this action plan, together with other essential indicators of health and social system actions (e.g. training and human resource levels, availability of psychotropic medicines, and admissions to hospital). The data need to be disaggregated by sex and age groups. Where needed, surveys can also be used to complement data from routine information systems. The Secretariat will advise countries on a set of core indicators to be collected in consultation with Member States. Data will be collected, analysed and reported by WHO on a global and regional basis (as part of WHO's Global Health Observatory).

APPENDIX 2

OPTIONS FOR THE IMPLEMENTATION OF THE COMPREHENSIVE MENTAL HEALTH ACTION PLAN 2013–2020

The actions proposed in this document for Member States convey *what* can be done to achieve the objectives of the action plan. This Appendix sets out some options for *how* these actions could be realized, recognizing the diversity of countries, particularly in terms of the level of development of mental health, health and social systems and resource availability. These options are neither comprehensive nor prescriptive, but provide illustrative or indicative mechanisms through which actions can be undertaken in countries.

Objective 1: To strengthen effective leadership and governance for mental health

Actions	Options for implementation
<p><i>Policy and law:</i> Develop, strengthen, keep up to date and implement national policies, strategies, programmes, laws and regulations relating to mental health within all relevant sectors, including protective monitoring mechanisms and codes of practice, in line with evidence, best practice, the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.</p>	<ul style="list-style-type: none"> • Set up a functional mental health unit or coordination mechanism in the health ministry, with responsibility for strategic planning, needs assessment, multisectoral collaboration and service evaluation. • Sensitize national policy-makers to mental health and human rights issues through the preparation of policy briefs and scientific publications and the provision of leadership courses in mental health. • Mainstream mental health and the rights of persons with mental disorders and psychosocial disabilities into all health and other sector policies and strategies including poverty reduction and development. • Improve accountability by setting up mechanisms, using existing independent bodies where possible, to monitor and prevent torture or cruel, inhuman and degrading treatment and other forms of ill treatment and abuse; and, involve appropriate stakeholder groups in these mechanisms, for example, lawyers and people with mental disorders and psychosocial disabilities, in a manner consistent with international and regional human rights instruments. • Repeal legislation that perpetuates stigmatization, discrimination and human rights violations against people with mental disorders and psychosocial disabilities. • Monitor and evaluate the implementation of policies and legislation to ensure compliance with the Convention on the Rights of Persons with Disabilities and feed this information into the reporting mechanism of that Convention.
<p><i>Resource planning:</i> Plan according to measured or systematically estimated need and allocate a budget, across all relevant sectors, that is commensurate with identified human and other resources required to implement agreed-upon, evidence-based mental health plans and actions.</p>	<ul style="list-style-type: none"> • Use – and if indicated, collect – data on epidemiological and resource needs in order to inform the development and implementation of mental health plans, budgets and programmes. • Set up mechanisms for tracking expenditure for mental health in health and other relevant sectors such as education, employment, criminal justice and social services. • Identify available funds at the planning stage for specific culturally-appropriate, cost-effective activities so that implementation can be assured. • Join with other stakeholders to effectively advocate increased resource allocation for mental health.

Actions	Options for implementation
<i>Stakeholder collaboration:</i> Engage stakeholders from all relevant sectors, including persons with mental disorders, carers and family members, in the development and implementation of policies, laws and services relating to mental health, through a formalized structure and/or mechanism.	<ul style="list-style-type: none"> • Convene, engage with and solicit consensus from all relevant sectors and stakeholders when planning or developing policies, laws and services relating to health, including sharing knowledge about effective mechanisms to improve coordinated policy and care across formal and informal sectors. • Build local capacity and raise awareness among relevant stakeholder groups about mental health, law and human rights, including their responsibilities in relation to the implementation of policy, laws and regulations.
<i>Strengthening and empowerment of people with mental disorders and psychosocial disabilities and their organizations:</i> Ensure that people with mental disorders and psychosocial disabilities are given a formal role and authority to influence the process of designing, planning and implementing policy, law and services.	<ul style="list-style-type: none"> • Provide logistic, technical and financial support to build the capacity of organizations representing people with mental disorders and psychosocial disabilities. • Encourage and support the formation of independent national and local organizations of people with mental disorders and psychosocial disabilities and their active involvement in the development and implementation of mental health policies, laws and services. • Involve people with mental disorders and psychosocial disabilities in the inspection and monitoring of mental health services. • Include people with mental disorders and psychosocial disabilities in the training of health workers delivering mental health care.

Objective 2: To provide comprehensive, integrated and responsive mental health and social care services in community-based settings

Actions	Options for implementation
<i>Service reorganization and expanded coverage:</i> Systematically shift the locus of care away from long-stay mental hospitals towards non-specialized health settings with increasing coverage of evidence-based interventions (including the use of stepped care principles, as appropriate) for priority conditions and using a network of linked community-based mental health services, including short-stay inpatient, and outpatient care in general hospitals, primary care, comprehensive mental health centres, day care centres, support of people with mental disorders living with their families, and supported housing.	<ul style="list-style-type: none"> • Develop a phased and budgeted plan for closing long-stay psychiatric institutions and replacing them with support for discharged patients to live in the community with their families. • Provide outpatient mental health services and an inpatient mental health unit in all general hospitals. • Build up community-based mental health services, including outreach services, home care and support, emergency care, community-based rehabilitation and supported housing. • Establish interdisciplinary community mental health teams to support people with mental disorders and their families/carers in the community. • Integrate mental health into disease-specific programmes such as HIV/AIDS and maternal, sexual and reproductive health programmes. • Engage service users and family members/carers with practical experience as peer support workers. • Support the establishment of community mental health services run by nongovernmental organizations, faith-based organizations and other community groups, including self-help and family support groups. • Develop and implement tools or strategies for self-help and care for persons with mental disorders, including the use of electronic and mobile technologies. • Include mental health services and basic medicines for mental disorders in health insurance schemes and offer financial protection for socioeconomically disadvantaged groups.

Actions	Options for implementation
<p><i>Integrated and responsive care:</i> Integrate and coordinate holistic prevention, promotion, rehabilitation, care and support that aims at meeting both mental and physical health care needs and facilitates the recovery of persons of all ages with mental disorders within and across general health and social services (including the promotion of the right to employment, housing and education) through service user-driven treatment and recovery plans, and where appropriate, with the inputs of families and carers.</p>	<ul style="list-style-type: none"> • Encourage health workers to link people with services and resources available from other sectors as a routine part of care (for example, livelihood opportunities, education and employment). • Advocate with other sectors (for example, housing, education, employment, social welfare) for the inclusion of people with psychosocial disabilities in their services and programmes. • Cultivate recovery-oriented care and support through awareness-building opportunities and training for health and social service providers. • Provide information to people with mental disorders, their families and carers on causes and consequences of disorders, treatment and recovery options, as well as on healthy lifestyle behaviours in order to improve overall health and well-being. • Foster the empowerment and involvement of persons with mental disorders, their families and caregivers in mental health care. • Procure and ensure the availability of basic medicines for mental disorders included in the WHO List of Essential Medicines at all health system levels, ensure their rational use and enable non-specialist health workers with adequate training to prescribe medicines. • Address the mental well-being of children when parents with severe illnesses (including those with mental disorders) are presenting for treatment at health services. • Provide services and programmes to children and adults who have experienced adverse life events, including ongoing domestic violence and civil unrest or conflict, that address people's trauma, promote recovery and resilience, and avoid re-traumatizing those who seek support. • Implement interventions to manage family crises and provide care and support to families and carers in primary care and other service levels. • Implement the use of WHO QualityRights standards to assess and improve quality and human rights conditions in inpatient and outpatient mental health and social care facilities.
<p><i>Mental health in humanitarian emergencies (including isolated, repeated or continuing conflict, violence, and disasters):</i> Work with national emergency committees to include mental health and psychosocial support needs in emergency preparedness, and enable access to safe and supportive services, including services that address psychological trauma and promote recovery and resilience, for persons with (pre-existing as well as emergency-induced) mental disorders or psychosocial problems, including for health and humanitarian workers, during and following emergencies, with due attention to the longer term funding required to build or rebuild a community-based mental health system after the emergency.</p>	<ul style="list-style-type: none"> • Work with national emergency committees on emergency preparedness actions as outlined in the Sphere Project's minimum standard on mental health and the Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings. • Prepare for emergencies by orienting health and community workers on psychological first aid and providing them with essential mental health information. • During emergencies, ensure coordination with partners on the application of the Sphere Project's minimum standard on mental health and the guidelines mentioned above. • After acute emergencies, build or rebuild sustainable community-based mental health systems to address the long-term increase in mental disorders in emergency-affected populations.

Actions	Options for implementation
<p><i>Human resource development:</i> Build the knowledge and skills of general and specialized health workers to deliver evidence-based, culturally-appropriate and human rights-oriented mental health and social care services, for children and adolescents, inter alia, by introducing mental health into undergraduate and graduate curricula; and through training and mentoring health workers in the field, particularly in non-specialized settings, to identify and offer treatment and support to people with mental disorders as well as to refer people, as appropriate, to other levels of care.</p>	<ul style="list-style-type: none"> • Develop and implement a strategy for building and retaining human resource capacity to deliver mental health and social care services in non-specialized health settings, such as primary health care and general hospitals. • Use WHO’s <i>mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized settings</i> (2010) and associated training and supervision materials to train health workers to identify disorders and provide evidence-based interventions for prioritized expanded care. • Collaborate with universities, colleges and other relevant educational entities to define and incorporate a mental health component in undergraduate and postgraduate curricula. • Ensure an enabling service context for training health workers including clear task definitions, referral structures, supervision and mentoring. • Improve the capacity of health and social care workers in all areas of their work (for example, covering clinical, human rights and public health domains), including eLearning methods where appropriate. • Improve working conditions, financial remuneration and career progression opportunities for mental health professionals and workers in order to attract and retain the mental health workforce.
<p><i>Address disparities:</i> Proactively identify and provide appropriate support for groups at particular risk of mental illness who have poor access to services.</p>	<ul style="list-style-type: none"> • Identify and assess the needs of different socio-demographic groups in the community and also vulnerable groups not using services (such as homeless people, children, older people, prisoners, migrants and minority ethnic groups, and people caught up in emergency situations). • Assess the barriers that “at risk” and vulnerable groups face in accessing treatment, care and support. • Develop a proactive strategy for targeting these groups and provide services that meet their needs. • Provide information and training to health and social care staff to help them better understand the needs of “at risk” and vulnerable groups.

Objective 3: To implement strategies for promotion and prevention in mental health

Actions	Options for implementation
<p><i>Mental health promotion and prevention:</i> Lead and coordinate a multisectoral strategy that combines universal and targeted interventions for: promoting mental health and preventing mental disorders; reducing stigmatization, discrimination and human rights violations; and which is responsive to specific vulnerable groups across the lifespan and integrated within the national mental health and health promotion strategies.</p>	<ul style="list-style-type: none"> • Increase public knowledge and understanding about mental health, for instance, through media awareness and campaigns to reduce stigmatization and discrimination and to promote human rights. • Include emotional and mental health as part of home- and health facility-based antenatal and postnatal care for new mothers and babies, including parenting skills training. • Provide early childhood programmes that address the cognitive, sensory-motor and psychosocial development of children as well as promote healthy child–parent relationships. • Reduce exposure to the harmful use of alcohol (by implementation of measures included in the global strategy to reduce the harmful use of alcohol). • Introduce brief interventions for hazardous and harmful substance use. • Implement programmes to prevent and address domestic violence, including attention to violence related to alcohol use.

Actions	Options for implementation
	<ul style="list-style-type: none"> • Provide services and programmes to children and adults who have experienced adverse life events that address their trauma, promote recovery and resilience, and avoid re-traumatizing those who seek support. • Protect children from abuse by introducing or strengthening community child protection networks and systems. • Address the needs of children with parents with chronic mental disorders within promotion and prevention programmes. • Develop school-based promotion and prevention, including: life/skills programmes; programmes to counter bullying and violence; awareness raising of the benefits of a healthy lifestyle and the risks of substance use; early detection and intervention for children and adolescents exhibiting emotional or behavioural problems. • Promote work participation and return-to-work programmes for those affected by mental and psychosocial disorders. • Promote safe and supportive working conditions, with attention to work organizational improvements, training on mental health for managers, the provision of stress management courses and workplace wellness programmes and tackling stigmatization and discrimination. • Enhance self-help groups, social support, community networks and community participation opportunities for people with mental disorders and psychosocial disabilities and other vulnerable groups. • Encourage the use of evidence-based traditional practices for promotion and prevention in mental health (such as yoga and meditation). • Enhance the use of social media in promotion and prevention strategies. • Implement preventive and control strategies for neglected tropical diseases (for instance, taeniasis and cysticercosis) in order to prevent epilepsy and other neurological and mental health problems. • Develop policies and measures for the protection of vulnerable populations during financial and economic crises.
<p><i>Suicide prevention:</i> Develop and implement comprehensive national strategies for the prevention of suicide, with special attention to groups identified as at increased risk of suicide, including lesbian, gay, bisexual and transgender persons, youth and other vulnerable groups of all ages based on local context.</p>	<ul style="list-style-type: none"> • Increase public, political and media awareness of the magnitude of the problem, and the availability of effective prevention strategies. • Restrict access to the means of self-harm and suicide (for instance, firearms and pesticides). • Promote responsible media reporting in relation to cases of suicide. • Promote workplace initiatives for suicide prevention. • Improve health system responses to self-harm and suicide. • Assess and manage self-harm/suicide and associated mental, neurological and substance use disorders (as outlined in the <i>mhGAP intervention guide</i>). • Optimize psychosocial support from available community resources both for those who have attempted suicide as well as for families of people who have committed suicide.

Objective 4: To strengthen information systems, evidence and research for mental health

Actions	Options for implementation
<p><i>Information systems:</i> Integrate mental health into the routine health information system and identify, collate, routinely report and use core mental health data disaggregated by sex and age (including on completed and attempted suicides) to</p>	<ul style="list-style-type: none"> • Establish an active surveillance system for mental health and suicide monitoring, ensuring that records are disaggregated by facility, sex, age and other relevant variables. • Embed mental health information needs and indicators, including risk factors and disabilities, within national population-based surveys and health information systems.

Actions	Options for implementation
improve mental health service delivery, promotion and prevention strategies and to feed into the Global Mental Health Observatory (as a part of WHO's Global Health Observatory).	<ul style="list-style-type: none"> • Collect detailed data from secondary and tertiary services in addition to routine data collected through the national health information system. • Include mental health indicators within information systems of other sectors.
<p><i>Evidence and research:</i> Improve research capacity and academic collaboration on national priorities for research in mental health, particularly operational research with direct relevance to service development and implementation and the exercise of human rights by persons with mental disorders, including the establishment of centres of excellence with clear standards, with the inputs of all relevant stakeholders including persons with mental disorders and psychosocial disabilities.</p>	<ul style="list-style-type: none"> • Develop a prioritized national research agenda in the area of mental health, based on consultation with all stakeholders. • Improve research capacity to assess needs and to evaluate services and programmes. • Enable strengthened cooperation between universities, institutes and health services in the field of mental health research. • Conduct research, in different cultural contexts, on local understandings and expressions of mental distress, harmful (for instance, human rights violations and discrimination) or protective (for instance, social supports and traditional customs) practices, as well as the efficacy of interventions for treatment and recovery, prevention and promotion. • Develop methods for characterizing mental health disparities that occur among diverse subpopulations in countries including factors such as race/ethnicity, sex, socioeconomic status and geography (urban versus rural). • Strengthen collaboration between national, regional and international research centres for mutual interdisciplinary exchange of research and resources between countries. • Promote high ethical standards in mental health research, ensuring that: research is conducted only with the free and informed consent of the person concerned; researchers do not receive any privileges, compensation or remuneration in exchange for encouraging or recruiting people to participate in the research; research is not undertaken if it is potentially harmful or dangerous; and all research is approved by an independent ethics committee functioning according to national and international norms and standards.

ANNEX 4

Global action plan for the prevention and control of noncommunicable diseases 2013–2020¹

[A66/8, A66/9 and A66/9 Corr.1 – 15 March, 6 May and 16 May 2013²]

Overview

Vision: A world free of the avoidable burden of noncommunicable diseases.
Goal: To reduce the preventable and avoidable burden of morbidity, mortality and disability due to noncommunicable diseases by means of multisectoral collaboration and cooperation at national, regional and global levels, so that populations reach the highest attainable standards of health and productivity at every age and those diseases are no longer a barrier to well-being or socioeconomic development.
Overarching principles: <ul style="list-style-type: none">• Life course approach• Empowerment of people and communities• Evidence-based strategies• Universal health coverage• Management of real, perceived or potential conflicts of interest• Human rights approach• Equity-based approach• National action and international cooperation and solidarity• Multisectoral action
Objectives
<ol style="list-style-type: none">1. To raise the priority accorded to the prevention and control of noncommunicable diseases in global, regional and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy.2. To strengthen national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response for the prevention and control of noncommunicable diseases.3. To reduce modifiable risk factors for noncommunicable diseases and underlying social determinants through creation of health-promoting environments.4. To strengthen and orient health systems to address the prevention and control of noncommunicable diseases and the underlying social determinants through people-centred primary health care and universal health coverage.5. To promote and support national capacity for high-quality research and development for the prevention and control of noncommunicable diseases.6. To monitor the trends and determinants of noncommunicable diseases and evaluate progress in their prevention and control.

¹ See resolution WHA66.10.

² See also the summary records of Committee A of the Sixty-sixth World Health Assembly at its first, eleventh and twelfth meetings for the evolution of this text, document WHA66/2013/REC/3.

Voluntary global targets
(1) A 25% relative reduction in the overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases
(2) At least 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context
(3) A 10% relative reduction in prevalence of insufficient physical activity
(4) A 30% relative reduction in mean population intake of salt/sodium
(5) A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years
(6) A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances
(7) Halt the rise in diabetes and obesity
(8) At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes
(9) An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases in both public and private facilities

Background

1. The global burden and threat of noncommunicable diseases constitutes a major public health challenge that undermines social and economic development throughout the world. Strong leadership and urgent action are required at the global, regional and national levels to mitigate them, which, inter alia, has the effect of increasing inequalities between countries and within populations.

2. An estimated 36 million deaths, or 63% of the 57 million deaths that occurred globally in 2008, were due to noncommunicable diseases, comprising mainly cardiovascular diseases (48% of noncommunicable diseases), cancers (21%), chronic respiratory diseases (12%) and diabetes (3.5%).^{1,2} These major noncommunicable diseases share four behavioural risk factors: tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol. In 2008, 80% of all deaths (29 million) from noncommunicable diseases occurred in low- and middle-income countries, and a higher proportion (48%) of the deaths in the latter countries are premature (under the age of 70) compared to high-income countries (26%). Although morbidity and mortality from noncommunicable diseases mainly occur in adulthood, exposure to risk factors begins in early life. Children can die from treatable noncommunicable diseases, such as rheumatic heart disease, type 1 diabetes, asthma, and leukaemia, if health promotion, disease prevention, and comprehensive care are not provided. According to WHO's projections, the total annual number of deaths from noncommunicable diseases will increase to 55 million by 2030, if "business as usual" continues. Scientific knowledge demonstrates that the noncommunicable disease burden can be greatly reduced if cost-effective preventive and curative actions and interventions for prevention and control of noncommunicable diseases already available, are implemented in an effective and balanced manner.

Aim

3. As requested by the World Health Assembly in resolution WHA64.11, the Secretariat has developed a global action plan for the prevention and control of noncommunicable diseases for the period 2013–2020, building on what has already been achieved through the implementation of the 2008–2013 action plan. Its aim is to operationalize the commitments of the Political Declaration of the

¹ Causes of death 2008: data sources and methods. Geneva, World Health Organization, 2011.

² *Global Status Report on noncommunicable diseases 2010*. Geneva, World Health Organization, 2010.

High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases.¹

Process

4. The global and regional consultation process to develop the action plan engaged WHO Member States, relevant United Nations system agencies, funds and programmes, international financial institutions, development banks and other key international organizations, health professionals, academia, civil society and the private sector through regional meetings organized by the six WHO regional offices, four web consultations, which received 325 written submissions, three informal consultations with Member States and two informal dialogues with relevant nongovernmental organizations and selected private sector entities.

Scope

5. The action plan provides a road map and a menu of policy options for all Member States and other stakeholders, to take coordinated and coherent action, at all levels, local to global, to attain the nine voluntary global targets, including that of a 25% relative reduction in premature mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by 2025.

6. The main focus of this action plan is on four types of noncommunicable disease – cardiovascular diseases, cancer, chronic respiratory diseases and diabetes – which make the largest contribution to morbidity and mortality due to noncommunicable diseases, and on four shared behavioural risk factors – tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol. It recognizes that the conditions in which people live and work and their lifestyles influence their health and quality of life. There are many other conditions of public health importance that are closely associated with the four major noncommunicable diseases. They include: (i) other noncommunicable diseases (renal, endocrine, neurological, haematological, gastroenterological, hepatic, musculoskeletal, skin and oral diseases, and genetic disorders); (ii) mental disorders; (iii) disabilities, including blindness and deafness; and (iv) violence and injuries (Appendix 1). Noncommunicable diseases and their risk factors also have strategic links to health systems and universal health coverage, environmental, occupational and social determinants of health, communicable diseases, maternal, child and adolescent health, reproductive health and ageing. Despite the close links, one action plan to address all of them in equal detail would be unwieldy. Further, some of these conditions are the subject of other WHO strategies and action plans or Health Assembly resolutions. Appendix 1 outlines potential synergies and linkages between major noncommunicable diseases and lists some of the interrelated conditions, to emphasize opportunities for collaboration in order to maximize efficiencies for mutual benefit. Linking the action plan in this manner also reflects WHO's responsiveness to the Organization's reform agenda as it relates to working in a more cohesive and integrated manner.

7. Using current scientific knowledge, available evidence and a review of experience on prevention and control of noncommunicable diseases, the action plan proposes a menu of policy options for Member States, international partners and the Secretariat, under six interconnected and mutually reinforcing objectives involving: (i) international cooperation and advocacy; (ii) country-led multisectoral response; (iii) risk factors and determinants; (iv) health systems and universal health coverage; (v) research, development and innovation; and (vi) surveillance and monitoring.

¹ United Nations General Assembly resolution 66/2.

Monitoring of the action plan

8. The global monitoring framework, including 25 indicators and a set of nine voluntary global targets (see Appendix 2), will track the implementation of the action plan through monitoring and reporting on the attainment of the voluntary global targets in 2015 and 2020. The action plan is not limited in scope to the global monitoring framework. The indicators of the global monitoring framework and the voluntary global targets provide overall direction and the action plan provides a road map for reaching the targets.

Relationship to the calls made upon WHO and its existing strategies, reform and plans

9. Since the adoption in 2000 of the global strategy for the prevention and control of noncommunicable diseases, several Health Assembly resolutions have been adopted or endorsed in support of the key components of the global strategy. This action plan builds on the implementation of those resolutions, mutually reinforcing them. They include the WHO Framework Convention on Tobacco Control (WHO FCTC) (resolution WHA56.1), the Global strategy on diet, physical activity and health (resolution WHA57.17), the Global strategy to reduce the harmful use of alcohol (resolution WHA63.13), Sustainable health financing structures and universal coverage (resolution WHA64.9) and the Global strategy and plan of action on public health, innovation and intellectual property (resolution WHA61.21). Also relevant are the Outcome of the World Conference on Social Determinants of Health (resolution WHA65.8) and the Moscow Declaration of the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control (resolution WHA64.11). The action plan also provides a framework to support and strengthen implementation of existing regional resolutions, frameworks, strategies and plans on prevention and control of noncommunicable diseases including AFR/RC62/WP/7, CSP28.R13, EMR/CR59/R2, EUR/RC61/R3, SEA/RC65/R5, WPR/RC62.R2. It has close conceptual and strategic links to the comprehensive mental health action plan 2013–2020¹ and the action plan for the prevention of avoidable blindness and visual impairment 2014–2019,² which were considered by the Sixty-sixth World Health Assembly. The action plan will also be guided by WHO's Twelfth General Programme of Work, 2014–2019.

10. The action plan is consistent with WHO's reform agenda, which requires the Organization to engage an increasing number of public health actors, including foundations, civil society organizations, partnerships and the private sector, in work related to the prevention and control of noncommunicable diseases. The roles and responsibilities of the three levels of the Secretariat – country offices, regional offices and headquarters – in the implementation of the action plan will be reflected in the Organization-wide workplans to be set out in WHO programme budgets.

11. Over the period 2013–2020, other plans with close linkages to noncommunicable diseases (such as the action plan on disability called for in resolution EB132.R5) may be developed and will need to be synchronized with this action plan. Further, flexibility is required for updating Appendix 3 of this action plan periodically in light of new scientific evidence. Flexibility will also be needed for reorienting parts of the action plan, as appropriate, through the governing bodies, in response to the United Nations post-2015 development agenda.

¹ Annex 3.

² Annex 2.

Cost of action versus inaction

12. For all countries, the cost of inaction far outweighs the cost of taking action on noncommunicable diseases as recommended in this action plan. There are interventions for prevention and control of noncommunicable diseases which give a good return on investment, generating one year of healthy life for a cost that falls below the gross domestic product (GDP) per person and are affordable for all countries¹ (see Appendix 3). The total cost of implementing a combination of very cost-effective population-wide and individual interventions, in terms of current health spending, amounts to 4% in low-income countries, 2% in lower middle-income countries and less than 1% in upper middle-income and high-income countries. The cost of implementing the action plan by the Secretariat is estimated at US\$ 940.26 million for the period 2013–2020. The above estimates for implementation of the action plan should be viewed against the cost of inaction. Continuing “business as usual” will result in loss of productivity and an escalation of health care costs in all countries. The cumulative output loss due to the four major noncommunicable diseases together with mental disorders is estimated to be US\$ 47 trillion. This loss represents 75% of global GDP in 2010 (US\$ 63 trillion).² This action plan should also be seen as an investment prospect, because it provides direction and opportunities for all countries to (i) safeguard the health and productivity of populations and economies; (ii) make informed decisions and choices related to, inter alia, food, media, information and communication technology, sports and health insurance; and (iii) identify the potential for new, replicable and scalable innovations that can be applied globally to reduce burgeoning health care costs in all countries.

Adaptation of framework to regional and national contexts

13. The framework provided in this action plan needs to be adapted at the regional and national levels, taking into account region-specific situations and in accordance with national legislation and priorities and specific national circumstances. There is no single formulation of an action plan that fits all countries, as they are at different points in their progress in the prevention and control of noncommunicable diseases and at different levels of socioeconomic development. However, all countries can benefit from the comprehensive response to the prevention and control of noncommunicable diseases presented in this action plan. There are cost-effective interventions and policy options across the six objectives (see Appendix 3), which, if implemented to scale, would enable all countries to make significant progress in attaining the nine voluntary global targets by 2025 (see Appendix 2). The exact manner in which sustainable national scale-up can be undertaken varies by country, being affected by each country’s level of socioeconomic development, degree of enabling political and legal climate, characteristics of the noncommunicable disease burden, competing national public health priorities, budgetary allocations for prevention and control of noncommunicable diseases, degree of universality of health coverage and health system strengthening, type of health system (e.g. centralized or decentralized) and national capacity.

Global coordination mechanism

14. The Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases reaffirms the leadership and coordination role of the World Health Organization in promoting and monitoring global action against noncommunicable diseases in relation to the work of other relevant United Nations system agencies, development banks and other regional and international organizations. In consultation with Member States, the WHO

¹ Scaling up action against noncommunicable disease: how much will it cost? Geneva, World Health Organization, 2011.

² The global economic burden of noncommunicable diseases. World Economic Forum and Harvard School of Public Health, 2011.

Secretariat plans to develop a global mechanism to coordinate the activities of the United Nations system and promote engagement, international cooperation, collaboration and accountability among all stakeholders.

15. The purpose of the proposed global mechanism is to improve coordination of activities that address functional gaps that are barriers to the prevention and control of noncommunicable diseases. The global coordination mechanism is to be developed based on the following parameters:

- The mechanism shall be convened, hosted and led by WHO and report to the WHO governing bodies.
- The primary role and responsibility for preventing and controlling noncommunicable diseases lie with governments, while efforts and engagement of all sectors of society, international collaboration and cooperation are essential for success.
- The global mechanism will facilitate engagement among Member States,¹ United Nations funds, programmes and agencies, and other international partners,² and non-State actors,³ while safeguarding WHO and public health from any form of real, perceived or potential conflicts of interest.
- The engagement with non-State Actors³ will follow the relevant rules currently being negotiated as part of WHO reform and to be considered, through the Executive Board, by the Sixty-seventh World Health Assembly.

Vision

16. A world free of the avoidable burden of noncommunicable diseases.

Goal

17. To reduce the preventable and avoidable burden of morbidity, mortality and disability due to noncommunicable diseases by means of multisectoral collaboration and cooperation at national, regional and global levels, so that populations reach the highest attainable standards of health, quality of life, and productivity at every age and those diseases are no longer a barrier to well-being or socioeconomic development.

Overarching principles and approaches

18. The action plan relies on the following overarching principles and approaches:

- **Human rights approach:** It should be recognized that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction

¹ And, where applicable, regional economic integration organizations.

² Without prejudice to ongoing discussions on WHO engagement with non-State actors, international partners are defined for this purpose as public health agencies with an international mandate, international development agencies, intergovernmental organizations including other United Nations organizations and global health initiatives, international financial institutions including the World Bank, foundations, and nongovernmental organizations.

³ Non-State actors include academia and relevant nongovernmental organizations, as well as selected private sector entities, as appropriate, excluding the tobacco industry, and including those that are demonstrably committed to promoting public health and are willing to participate in public reporting and accountability frameworks.

of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, as enshrined in the Universal Declaration of Human Rights.

- **Equity-based approach:** It should be recognized that the unequal burden of noncommunicable diseases is influenced by the social determinants of health, and that action on these determinants, both for vulnerable groups and the entire population, is essential to reduce the overall burden of noncommunicable diseases and create inclusive, equitable, economically productive and healthy societies.
- **National action and international cooperation and solidarity:** The primary role and responsibility of governments in responding to the challenge of noncommunicable diseases should be recognized, together with the important role of international cooperation in supporting Member States, as a complement to national efforts.
- **Multisectoral action:** It should be recognized that effective noncommunicable disease prevention and control require leadership, coordinated multistakeholder engagement and multisectoral action for health both at government level and at the level of a wide range of actors, with such engagement and action including, as appropriate, health-in-all-policies and whole-of-government approaches across sectors such as health, agriculture, communication, education, employment, energy, environment, finance, food, foreign affairs, housing, justice and security, legislature, social welfare, social and economic development, sports, tax and revenue, trade and industry, transportation, urban planning and youth affairs and partnership with relevant civil society and private sector entities.
- **Life course approach:** Opportunities to prevent and control noncommunicable diseases occur at multiple stages of life; interventions in early life often offer the best chance for primary prevention. Policies, plans and services for the prevention and control of noncommunicable diseases need to take account of health and social needs at all stages of the life course, starting with maternal health, including preconception, antenatal and postnatal care, maternal nutrition and reducing environmental exposures to risk factors, and continuing through proper infant feeding practices, including promotion of breastfeeding and health promotion for children, adolescents and youth followed by promotion of a healthy working life, healthy ageing and care for people with noncommunicable diseases in later life.
- **Empowerment of people and communities:** People and communities should be empowered and involved in activities for the prevention and control of noncommunicable diseases, including advocacy, policy, planning, legislation, service provision, education and training, monitoring, research and evaluation.
- **Evidence-based strategies:** Strategies and practices for the prevention and control of noncommunicable diseases need to be based on scientific evidence and/or best practice, cost-effectiveness, affordability and public health principles, taking cultural considerations into account.
- **Universal health coverage:** All people should have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative, and rehabilitative and palliative basic health services and essential, safe, affordable, effective and quality medicines and diagnostics. At the same time it must be ensured that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor and populations living in vulnerable situations.
- **Management of real, perceived or potential conflicts of interest:** Multiple actors, both State and non-State actors, including civil society, academia, industry, nongovernmental and

professional organizations, need to be engaged for noncommunicable diseases to be tackled effectively. Public health policies for the prevention and control of noncommunicable diseases must be protected from undue influence by any form of vested interest. Real, perceived or potential conflicts of interest must be acknowledged and managed.

Objective 1. To raise the priority accorded to the prevention and control of noncommunicable diseases in global, regional and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy

19. The Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, the outcome document of the United Nations Conference on Sustainable Development (Rio+20) and the first report of the UN System Task Team on the Post-2015 UN Development Agenda¹ have acknowledged that addressing noncommunicable diseases is a priority for social development and investment in people. Better health outcomes from noncommunicable diseases is a precondition for, an outcome of, and an indicator of all three dimensions of sustainable development: economic development, environmental sustainability, and social inclusion.

20. Advocacy and international cooperation are vital for resource mobilization, capacity strengthening and advancing the political commitment and momentum generated by the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. Actions listed under this objective are aimed at creating enabling environments at the global, regional and country levels for the prevention and control of noncommunicable diseases. The desired outcomes of this objective are strengthened international cooperation, stronger advocacy, enhanced resources, improved capacity and creation of enabling environments to attain the nine voluntary global targets (see Appendix 2).

Policy options for Member States²

21. It is proposed that, in accordance with their legislation, and as appropriate in view of their specific circumstances, Member States may select and undertake actions from among the policy options set out below.

(a) **Advocacy:** Generate actionable evidence and disseminate information about the effectiveness of interventions or policies to intervene positively on linkages between noncommunicable diseases and sustainable development, including other related issues such as poverty alleviation, economic development, the Millennium Development Goals, sustainable cities, non-toxic environment, food security, climate change, disaster preparedness, peace and security and gender equality, based on national situations.

(b) **Broader health and development agenda:** Promote universal health coverage as a means of prevention and control of noncommunicable diseases, and its inclusion as a key element in the internationally agreed development goals; integrate the prevention and control of noncommunicable diseases into national health planning processes and broader development agendas, according to country context and priorities, and, where relevant, mobilize the United Nations Country Teams to strengthen the links among noncommunicable diseases, universal

¹ Realizing the Future We Want for All, Report to the Secretary-General. New York, UN System Task Team on the Post-2015 UN Development Agenda, 2012.

² And, where applicable, regional economic integration organizations.

health coverage and sustainable development, integrating them into the United Nations Development Assistance Framework's design processes and implementation.

(c) **Partnerships:** Forge multisectoral partnerships as appropriate, to promote cooperation at all levels among governmental agencies, intergovernmental organizations, nongovernmental organizations, civil society and the private sector to strengthen efforts for prevention and control of noncommunicable diseases.

Actions for the Secretariat

22. The following actions are envisaged for the Secretariat:

(a) **Leading and convening:** Facilitate coordination, collaboration and cooperation among the main stakeholders including Member States, United Nations funds, programmes and agencies (see Appendix 4), civil society and the private sector, as appropriate, guided by the Note by the Secretary-General transmitting the report of the Director-General of WHO on options for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases through effective partnership,¹ including the strengthening of regional coordinating mechanisms and establishment of a United Nations task force on noncommunicable diseases for implementation of the action plan.

(b) **Technical cooperation:** Offer technical support and strengthen global, regional and national capacity to raise public awareness about the links between noncommunicable diseases and sustainable development, to integrate the prevention and control of noncommunicable diseases into national health-planning processes and development agendas, the United Nations Development Assistance Framework and poverty-alleviation strategies.

(c) **Provision of policy advice and dialogue:** This will include:

- Addressing the interrelationships between the prevention and control of noncommunicable diseases and initiatives on poverty alleviation and sustainable development in order to promote policy coherence.
- Strengthening governance, including management of real, perceived or potential conflicts of interest, in engaging non-State actors in collaborative partnerships for implementation of the action plan, in accordance with the new principles and policies being developed as part of WHO reform.
- Increasing revenues for prevention and control of noncommunicable diseases through domestic resource mobilization, and improve budgetary allocations particularly for strengthening of primary health care systems and provision of universal health coverage. Also, consideration of economic tools, where justified by evidence, which may include taxes and subsidies, that create incentives for behaviours associated with improved health outcomes, as appropriate within the national context.

(d) **Dissemination of best practices:** Promote and facilitate international and intercountry collaboration for exchange of best practices in the areas of health-in-all policies, whole-of-government and whole-of-society approaches, legislation, regulation, health system

¹ United Nations General Assembly document A/67/373.

strengthening and training of health personnel, so as to disseminate learning from the experiences of Member States in meeting the challenges.

Proposed actions for international partners and the private sector

23. Without prejudice to ongoing discussions on WHO engagement with non-State actors, international partners are defined for the present purpose as public health agencies with an international mandate, international development agencies, intergovernmental organizations including other United Nations organizations and global health initiatives, international financial institutions including the World Bank, foundations, and nongovernmental organizations and selected private sector entities that commit to the objectives of the action plan and including those that are demonstrably committed to promoting public health and are willing to participate in public reporting and accountability frameworks. Proposed actions include:

(a) Encouraging the continued inclusion of noncommunicable diseases in development cooperation agendas and initiatives, internationally-agreed development goals, economic development policies, sustainable development frameworks and poverty-reduction strategies.

(b) Strengthening advocacy to sustain the interest of Heads of State and Government in implementation of the commitments of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, for instance by strengthening capacity at global, regional and national levels, involving all relevant sectors, civil society and communities, as appropriate within the national context, with the full and active participation of people living with these diseases.

(c) Strengthening international cooperation within the framework 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.
- Support national efforts for prevention and control of noncommunicable diseases, inter alia, through exchange of information on best practices and dissemination of research findings in the areas of health promotion, legislation, regulation, monitoring and evaluation and health system strengthening, building of institutional capacity, training of health personnel, and development of appropriate health care infrastructure.
- Promote the development and dissemination of appropriate, affordable and sustainable transfer of technology on mutually agreed terms for the production of affordable, safe, effective and quality medicines and vaccines, diagnostics and medical technologies, the creation of information and electronic communication technologies (eHealth) and the use of mobile and wireless devices (mHealth).
- Strengthen existing alliances and initiatives and forge new collaborative partnerships as appropriate, to strengthen capacity for adaptation, implementation, monitoring and evaluation of the action plan for prevention and control of noncommunicable diseases at global, regional and national levels.

(d) Support the coordinating role of WHO in areas where stakeholders – including nongovernmental organizations, professional associations, academia, research institutions and the private sector – can contribute and take concerted action against noncommunicable diseases.

- (e) Support the informal collaborative arrangement among United Nations agencies, convened by WHO for prevention and control of noncommunicable diseases.
- (f) Fulfil the official development assistance commitment.¹

Objective 2. To strengthen national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response for the prevention and control of noncommunicable diseases

24. As the ultimate guardians of a population's health, governments have the lead responsibility for ensuring that appropriate institutional, legal, financial and service arrangements are provided for the prevention and control of noncommunicable diseases.

25. Noncommunicable diseases undermine the achievement of the Millennium Development Goals and are contributory to poverty and hunger. Strategies to address noncommunicable diseases need to deal with health inequities that arise from the societal conditions in which people are born, grow, live and work and to mitigate barriers to childhood development, education, economic status, employment, housing and environment. Upstream policy and multisectoral action to address these social determinants of health will be critical for achieving sustained progress in prevention and control of noncommunicable diseases.

26. Universal health coverage, people-centred primary health care and social protection mechanisms are important tools to protect people from financial hardship related to noncommunicable diseases and to provide access to health services for all, in particular for the poorest segments of the population. Universal health coverage needs to be established and/or strengthened at the country level, to support the sustainable prevention and control of noncommunicable diseases.

27. Effective noncommunicable disease prevention and control require multisectoral approaches at the government level, including, as appropriate, a whole-of-government, whole-of-society and health-in-all policies approach across such sectors as health, agriculture, communication, customs/revenue, education, employment/labour, energy, environment, finance, food, foreign affairs, housing, industry, justice/security, legislature, social welfare, social and economic development, sports, trade, transport, urban planning and youth affairs (Appendix 5). Approaches to be considered to implement multisectoral action could include, inter alia, (i) self-assessment of Ministry of Health, (ii) assessment of other sectors required for multisectoral action, (iii) analyses of areas which require multisectoral action, (iv) development of engagement plans, (v) use of a framework to foster common understanding between sectors, (vi) strengthening of governance structures, political will and accountability mechanisms, (vii) enhancement of community participation, (viii) adoption of other good practices to foster intersectoral action and (ix) monitoring and evaluation.

28. An effective national response for prevention and control of noncommunicable diseases requires multistakeholder engagement, to include individuals, families and communities, intergovernmental organizations, religious institutions, civil society, academia, the media, policy-makers, voluntary associations and, where appropriate, traditional medicine practitioners, the private sector and industry. The active participation of civil society in efforts to address noncommunicable diseases, particularly the participation of grass roots organizations representing people living with noncommunicable diseases and their carers, can empower society and improve accountability of public health policies, legislation and services, making them acceptable, responsive to needs and supportive, in order that individuals reach the

¹ United Nations General Assembly, United Approach to Development. Report on the Second United Nations Development Decade. New York, United Nations, 1970 (document A/8124).

highest attainable standard of health and well-being. Member States can also promote change to improve social and physical environments and enable progress against noncommunicable diseases including through constructive engagement with relevant private sector actors.

29. The desired outcomes of this objective are strengthened stewardship and leadership, increased resources, improved capacity and creation of enabling environments for forging a collaborative multisectoral response at national level, in order to attain the nine voluntary global targets (see Appendix 2).

Policy options for Member States¹

30. It is proposed that, in accordance with their legislation, and as appropriate in view of their specific circumstances, Member States may select and undertake actions from among the policy options set out below.

(a) **Enhance governance:** Integrate the prevention and control of noncommunicable diseases into health-planning processes and development plans, with special attention to social determinants of health, gender equity and the health needs of people living in vulnerable situations, including indigenous peoples, migrant populations and people with mental and psychosocial disabilities.

(b) **Mobilize sustained resources: As appropriate to national context, and in coordination with the relevant organizations and ministries, including the Ministry of Finance**

- Strengthen the provision of adequate, predictable and sustained resources for prevention and control of noncommunicable diseases and for universal health coverage, through an increase in domestic budgetary allocations, voluntary innovative financing mechanisms and other means, including multilateral financing, bilateral sources and private sector and/or nongovernmental sources, and
- Improve efficiency of resource utilization including through synergy of action, integrated approaches and shared planning across sectors.

(c) **Strengthen national noncommunicable diseases programmes:** Strengthen programmes for the prevention and control of noncommunicable diseases with suitable expertise, resources and responsibility for needs assessment, strategic planning, policy development, legislative action, multisectoral coordination, implementation, monitoring and evaluation.

(d) **Conduct needs assessment and evaluation:** Conduct periodic assessments of epidemiological and resource needs, including workforce, institutional and research capacity; of the health impact of policies in sectors beyond health (e.g. agriculture, communication, education, employment, energy, environment, finance, industry and trade, justice, labour, sports, transport and urban planning) and of the impact of financial, social and economic policies on noncommunicable diseases, in order to inform country action.

(e) **Develop national plan and allocate budget:** As appropriate to national context, develop and implement a national multisectoral noncommunicable disease policy and plan; and taking into account national priorities and domestic circumstances, in coordination with the relevant

¹ And, where applicable, regional economic integration organizations.

organizations and ministries, including the Ministry of Finance, increase and prioritize budgetary allocations for addressing surveillance, prevention, early detection and treatment of noncommunicable diseases and related care and support, including palliative care.

(f) **Strengthen multisectoral action:** As appropriate to the national context, set up a national multisectoral mechanism – high-level commission, agency or task force – for engagement, policy coherence and mutual accountability of different spheres of policy-making that have a bearing on noncommunicable diseases, in order to implement health-in-all-policies and whole-of-government and whole-of-society approaches, to convene multistakeholder working groups, to secure budgetary allocations for implementing and evaluating multisectoral action and to monitor and act on the social and environmental determinants of noncommunicable diseases (see Appendix 5).

(g) **Improve accountability:** Improve accountability for implementation by assuring adequate surveillance, monitoring and evaluation capacity, and by setting up a monitoring framework with national targets and indicators consistent with the global monitoring framework and options for applying it at the country level.

(h) **Strengthen institutional capacity and the workforce:** Provide training and appropriately deploy health, social services and community workforce, and strengthen institutional capacity for implementing the national action plan, for example by including prevention and control of noncommunicable diseases in the teaching curricula for medical, nursing and allied health personnel, providing training and orientation to personnel in other sectors and by establishing public health institutions to deal with the complexity of issues relating to noncommunicable diseases (including such factors as multisectoral action, advertising, human behaviour, health economics, food and agricultural systems, law, business management, psychology, trade, commercial influence including advertising of unhealthy commodities to children and limitations of industry self-regulation, urban planning, training in prevention and control of noncommunicable diseases, integrated primary care approaches and health promotion).

(i) **Forge partnerships:** Lead collaborative partnerships to address implementation gaps (e.g. in the areas of community engagement, training of health personnel, development of appropriate health care infrastructure, and sustainable transfer of technology on mutually agreed terms for the production of affordable, quality, safe and efficacious medicines, including generics, vaccines and diagnostics, as well as for product access and procurement), as appropriate to national contexts.

(j) **Empower communities and people:** Facilitate social mobilization, engaging and empowering a broad range of actors, including women as change-agents in families and communities, to promote dialogue, catalyse societal change and shape a systematic society-wide national response to address noncommunicable diseases, their social, environmental and economic determinants and health equity (e.g. through engaging human rights organizations, faith-based organizations, labour organizations, organizations focused on children, adolescents, youth, adults, elderly, women, patients and people with disabilities, indigenous peoples, intergovernmental and nongovernmental organizations, civil society, academia, media and the private sector).

Actions for the Secretariat

31. The following actions are envisaged for the Secretariat:

(a) **Leading and convening:** Mobilize the United Nations system to work as one within the scope of bodies' respective mandates, based on an agreed division of labour, and synergize the efforts of different United Nations organizations as per established informal collaborative arrangements among United Nations agencies in order to provide additional support to Member States.

(b) **Technical cooperation:** Provide support to countries in evaluating and implementing evidence-based options that suit their needs and capacities and in assessing the health impact of public policies, including on trade, management of conflicts of interest and maximizing of intersectoral synergies for the prevention and control of noncommunicable diseases (see Appendix 1) across programmes for environmental health, occupational health, and for addressing noncommunicable diseases during disasters and emergencies. Such support to be given by establishing/strengthening national reference centres, WHO collaborating centres and knowledge-sharing networks.

(c) **Policy guidance and dialogue:** Provide guidance for countries in developing partnerships for multisectoral action to address functional gaps in the response for prevention and control of noncommunicable diseases, guided by the Note of the Secretary-General transmitting the report of the Director-General, in particular addressing the gaps identified in that report, including advocacy, awareness-raising, accountability including management of real, perceived or potential conflicts of interest at the national level, financing and resource mobilization, capacity strengthening, technical support, product access, market shaping and product development and innovation.

(d) **Knowledge generation:** Develop, where appropriate, technical tools, decision support tools and information products for implementation of cost-effective interventions, for assessing the potential impact of policy choices on equity and on social determinants of health, for monitoring multisectoral action for the prevention and control of noncommunicable diseases, for managing conflicts of interest and for communication, including through social media, tailored to the capacity and resource availability of countries.

(e) **Capacity strengthening:**

- Develop a "One-WHO workplan for the prevention and control of noncommunicable diseases" to ensure synergy and alignment of activities across the three levels of WHO, based on country needs.
- Strengthen the capacity of the Secretariat at all levels to support Member States in implementing the action plan, recognizing the key role played by WHO country offices working directly with relevant national Ministries, agencies and nongovernmental organizations.
- Facilitate and support capacity assessment surveys of Member States to identify needs and tailor the provision of support from the Secretariat and other agencies.

Proposed actions for international partners

32. Strengthen international cooperation within the framework of North–South, South–South and triangular cooperation, and forge collaborative partnerships as appropriate, to:

(a) Support national authorities in implementing evidence-based multisectoral action (see Appendix 5), to address functional gaps in the response to noncommunicable diseases (e.g. in the areas of advocacy, strengthening of health workforce and institutional capacity, capacity building, product development, access and innovation), in implementing existing international conventions in the areas of environment and labour and in strengthening health financing for universal health coverage.

(b) Promote capacity-building of relevant nongovernmental organizations at the national, regional and global levels, in order to realize their full potential as partners in the prevention and control of noncommunicable diseases.

(c) Facilitate the mobilization of adequate, predictable and sustained financial resources and the necessary human and technical resources to support the implementation of national action plans and the monitoring and evaluation of progress.

(d) Enhance the quality of aid for prevention and control of noncommunicable diseases by strengthening national ownership, alignment, harmonization, predictability, mutual accountability and transparency, and results orientation.

(e) Support social mobilization to implement the action plan and to promote equity in relation to the prevention and control of noncommunicable diseases including through creating and strengthening associations of people with those diseases as well as supporting families and carers, and facilitate dialogue among those groups, health workers and government authorities in health and relevant outside sectors such as the human rights, education, employment, judicial and social sectors.

(f) Support national plans for the prevention and control of noncommunicable diseases through the exchange of best practices and by promoting the development and dissemination of appropriate, affordable and sustainable transfer of technology on mutually agreed terms.

(g) Support countries and the Secretariat in implementing other actions set out in this objective.

Objective 3. To reduce modifiable risk factors for noncommunicable diseases and underlying social determinants through creation of health-promoting environments

33. The Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases recognizes the critical importance of reducing the level of exposure of individuals and populations to the common modifiable risk factors for noncommunicable diseases, while strengthening the capacity of individuals and populations to make healthier choices and follow lifestyle patterns that foster good health. While deaths from noncommunicable diseases mainly occur in adulthood, exposure to risk factors begins in childhood and builds up throughout life, underpinning the importance of legislative and regulatory measures, as appropriate, and health

promotion interventions that engage State and non-State actors¹ from within and outside the health sectors, to prevent tobacco use, physical inactivity, unhealthy diet, obesity and harmful use of alcohol and to protect children from adverse impacts of marketing.

34. Governments should be the key stakeholders in the development of a national policy framework for promoting health and reducing risk factors. At the same time, it must be recognized that the effectiveness of multisectoral action requires allocation of defined roles to other stakeholders, protection of the public interest and avoidance of any undue influence from conflicts of interest. Further, supportive environments that protect physical and mental health and promote healthy behaviour need to be created through multisectoral action (see Appendix 5), using incentives and disincentives, regulatory and fiscal measures, laws and other policy options, and health education, as appropriate within the national context, with a special focus on maternal health (including preconception, antenatal and postnatal care, and maternal nutrition), children, adolescents and youth, including prevention of childhood obesity (See Appendix 1).

35. The effective implementation of actions listed under this objective will enable countries to contribute to voluntary global targets related to risk factors, as well as to the premature mortality target. It is proposed that, in accordance with their nation's legislative, religious and cultural contexts, and in accordance with constitutional principles and international legal obligations, Member States may select and undertake actions from among the policy options set out below.

Policy options for Member States:² tobacco control

36. The proposed policy options aim to contribute to achieving the voluntary global target of a 30% relative reduction in prevalence of current tobacco use in persons aged 15 years or older. They include:

(a) Accelerate full implementation of the WHO Framework Convention on Tobacco Control (FCTC). Member States that have not yet become party to the WHO FCTC should consider action to ratify, accept, approve, formally confirm or accede to it at the earliest opportunity, in accordance with resolution WHA56.1 and the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases.

(b) In order to reduce tobacco use and exposure to tobacco smoke, utilize the guidelines adopted by the Conference of the Parties to the WHO Framework Convention on Tobacco Control for implementation of the following measures as part of a comprehensive multisectoral package:

- Protect tobacco control policies from commercial and other vested interests of the tobacco industry in accordance with national law, consistent with Article 5.3 of the WHO FCTC.
- Legislate for 100% tobacco smoke-free environments in all indoor workplaces, public transport, indoor public places and, as appropriate, other public places, consistent with Article 8 (Protection from exposure to tobacco smoke) of the WHO FCTC.

¹ Non-State actors include academia and relevant nongovernmental organizations, as well as selected private sector entities, as appropriate, excluding the tobacco industry, and including those that are demonstrably committed to promoting public health and are willing to participate in public reporting and accountability frameworks.

² And, where applicable, regional economic integration organizations.

- Warn people about the dangers of tobacco use, including through evidence-based hard-hitting mass-media campaigns and large, clear, visible and legible health warnings, consistent with Articles 11 (Packaging and labelling of tobacco products) and 12 (Education, communication, training and public awareness) of the WHO FCTC.
 - Implement comprehensive bans on tobacco advertising, promotion and sponsorship, consistent with Article 13 (Tobacco advertising, promotion and sponsorship) of the WHO FCTC.
 - Offer help to people who want to stop using tobacco, or reduce their exposure to environmental tobacco smoke, especially pregnant women, consistent with Article 14 (Demand reduction measures concerning tobacco dependence and cessation) of the WHO FCTC.
 - Regulate the contents and emissions of tobacco products and require manufacturers and importers of tobacco products to disclose to governmental authorities information about the contents and emissions of tobacco products, consistent with Articles 9 (Regulation of the contents of tobacco products) and 10 (Regulation of tobacco product disclosures) of the WHO FCTC.
 - In accordance with the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and the guidance provided by the Conference of the Parties to the WHO FCTC, raise taxes on all tobacco products, to reduce tobacco consumption, consistent with Article 6 (Price and tax measures to reduce the demand for tobacco) of the WHO FCTC.
- (c) In order to facilitate the implementation of comprehensive multisectoral measures in line with the WHO FCTC, take the following action:
- Monitor tobacco use, particularly including initiation by and current tobacco use among youth, in line with the indicators of the global monitoring framework, and monitor the implementation of tobacco control policies and measures consistent with Articles 20 (Research, surveillance and exchange of information) and 21 (Reporting and exchange of information) of the WHO FCTC.
 - Establish or reinforce and finance a national coordinating mechanism or focal points for tobacco control, consistent with Article 5 (General obligations) of the WHO FCTC.
 - Establish or reinforce and finance mechanisms to enforce adopted tobacco control policies, consistent with Article 26 (Financial resources) of the WHO FCTC.

Policy options for Member States:¹ promoting a healthy diet

37. The proposed policy options are intended to advance the implementation of global strategies and recommendations to make progress towards the voluntary global targets set out below:

- A 30% relative reduction in mean population intake of salt/sodium
- A halt in the rise in diabetes and obesity

¹ And, where applicable, regional economic integration organizations.

- A 25% relative reduction in the prevalence of raised blood pressure or containment of the prevalence of raised blood pressure according to national circumstances.

38. Member States should consider developing or strengthening national food and nutrition policies and action plans and implementation of related global strategies including the global strategy on diet, physical activity and health, the global strategy for infant and young child feeding, the comprehensive implementation plan on maternal, infant and young child nutrition and WHO's set of recommendations on the marketing of foods and non-alcoholic beverages to children. Member States should also consider implementing other relevant evidence-guided strategies, to promote healthy diets in the entire population (see Appendix 1 and Appendix 3), while protecting dietary guidance and food policy from undue influence of commercial and other vested interests.

39. Such policies and programmes should include a monitoring and evaluation plan and would aim to:

(a) Promote and support exclusive breastfeeding for the first six months of life, continued breastfeeding until two years old and beyond and adequate and timely complementary feeding.

(b) Implement WHO's set of recommendations on the marketing of foods and non-alcoholic beverages to children, including mechanisms for monitoring.

(c) Develop guidelines, recommendations or policy measures that engage different relevant sectors, such as food producers and processors, and other relevant commercial operators, as well as consumers, to:

- Reduce the level of salt/sodium added to food (prepared or processed)
- Increase availability, affordability and consumption of fruit and vegetables
- Reduce saturated fatty acids in food and replace them with unsaturated fatty acids
- Replace *trans*-fats with unsaturated fats
- Reduce the content of free and added sugars in food and non-alcoholic beverages
- Limit excess calorie intake, reduce portion size and energy density of foods.

(d) Develop policy measures that engage food retailers and caterers to improve the availability, affordability and acceptability of healthier food products (plant foods, including fruit and vegetables, and products with reduced content of salt/sodium, saturated fatty acids, *trans*-fatty acids and free sugars).

(e) Promote the provision and availability of healthy food in all public institutions including schools, other educational institutions and the workplace.¹

(f) As appropriate to national context, consider economic tools that are justified by evidence, and may include taxes and subsidies, that create incentives for behaviours associated with improved health outcomes, improve the affordability and encourage consumption of healthier food products and discourage the consumption of less healthy options.

¹ For example, through nutrition standards for public sector catering establishments and use of government contracts for food purchasing.

- (g) Develop policy measures in cooperation with the agricultural sector to reinforce the measures directed at food processors, retailers, caterers and public institutions, and provide greater opportunities for utilization of healthy agricultural products and foods.
- (h) Conduct evidence-informed public campaigns and social marketing initiatives to inform and encourage consumers about healthy dietary practices. Campaigns should be linked to supporting actions across the community and within specific settings for maximum benefit and impact.
- (i) Create health- and nutrition-promoting environments, including through nutrition education, in schools, child care centres and other educational institutions, workplaces, clinics and hospitals, and other public and private institutions.
- (j) Promote nutrition labelling, according but not limited to, international standards, in particular the Codex Alimentarius, for all pre-packaged foods including those for which nutrition or health claims are made.

Policy options for Member States:¹ promoting physical activity

40. The proposed policy options are intended to advance the implementation of the global strategy on diet, physical activity and health and other relevant strategies, and to promote the ancillary benefits from increasing population levels of physical activity, such as improved educational achievement and social and mental health benefits, together with cleaner air, reduced traffic, less congestion and the links to healthy child development and sustainable development (see Appendix 1). In addition, interventions to increase participation in physical activity in the entire population for which favourable cost-effectiveness data are emerging should be promoted. The aim is to contribute to achieving the voluntary global targets listed below:

- A 10% relative reduction in prevalence of insufficient physical activity
- Halt the rise in diabetes and obesity
- A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure according to national circumstances.

41. The proposed policy options include:

- (a) Adopt and implement national guidelines on physical activity for health.
- (b) Consider establishing a multisectoral committee or similar body to provide strategic leadership and coordination.
- (c) Develop appropriate partnerships and engage all stakeholders, across governments, nongovernmental organizations and civil society and economic operators, in actively and appropriately implementing actions aimed at increasing physical activity across all ages.
- (d) Develop policy measures in cooperation with relevant sectors to promote physical activity through activities of daily living, including through “active transport,” recreation, leisure and sport, for example:

¹ And, where applicable, regional economic integration organizations.

- National and subnational urban planning and transport policies to improve the accessibility, acceptability and safety of, and supportive infrastructure for, walking and cycling.
 - Improved provision of quality physical education in educational settings (from infant years to tertiary level) including opportunities for physical activity before, during and after the formal school day.
 - Initiatives to support and encourage “physical activity for all” initiatives for all ages.
 - Creation and preservation of built and natural environments which support physical activity in schools, universities, workplaces, clinics and hospitals, and in the wider community, with a particular focus on providing infrastructure to support active transport, such as walking and cycling, active recreation and play, and participation in sports.
 - Promotion of community involvement in implementing local actions aimed at increasing physical activity.
- (e) Conduct evidence-informed public campaigns through mass media, social media and at the community level and social marketing initiatives to inform and motivate adults and young people about the benefits of physical activity and to facilitate healthy behaviours. Campaigns should be linked to supporting actions across the community and within specific settings for maximum benefit and impact.
- (f) Encourage the evaluation of actions aimed at increasing physical activity, to contribute to the development of an evidence base of effective and cost-effective actions.

Policy options for Member States:¹ reducing the harmful use of alcohol²

42. Proposed policy options are intended to advance the adoption and implementation of the global strategy to reduce the harmful use of alcohol and to mobilize political will and financial resources for that purpose in order to contribute to achieving the voluntary global targets listed below:

- At least a 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context.
- A 25% relative reduction in the prevalence of raised blood pressure or containment of the prevalence of raised blood pressure, according to national circumstances.

43. Proposed actions for Member States are set out below:

- (a) **Multisectoral national policies:** Develop and implement, as appropriate, comprehensive and multisectoral national policies and programmes to reduce the harmful use of alcohol as outlined in the global strategy to reduce the harmful use of alcohol, addressing the general levels, patterns and contexts of alcohol consumption and the wider social determinants of health in a

¹ And, where applicable, regional economic integration organizations.

² The word “harmful” in this action plan refers only to public health effects of alcohol consumption, without prejudice to religious beliefs and cultural norms in any way.

population (see Appendix 1). The global strategy to reduce the harmful use of alcohol recommends the following 10 target areas for national policies and programmes:

- leadership, awareness and commitment
- health services' response
- community action
- drink–driving policies and countermeasures
- availability of alcohol
- marketing of alcoholic beverages
- pricing policies
- reducing the negative consequences of drinking and alcohol intoxication
- reducing the public health impact of illicit alcohol and informally produced alcohol
- monitoring and surveillance.

(b) **Public health policies:** Formulate public health policies and interventions to reduce the harmful use of alcohol based on clear public health goals, existing best practices, best available knowledge and evidence of effectiveness and cost–effectiveness generated in different contexts.

(c) **Leadership:** Strengthen capacity and empower health ministries to assume a crucial role in bringing together other ministries and stakeholders as appropriate for effective public policy development and implementation to prevent and reduce the harmful use of alcohol while protecting those policies from undue influence of commercial and other vested interests.

(d) **Capacity:** Increase the capacity of health care services to deliver prevention and treatment interventions for hazardous use of alcohol and alcohol use disorders, including screening and brief interventions in all settings providing treatment and care for noncommunicable diseases.

(e) **Monitoring:** Develop effective frameworks for monitoring the harmful use of alcohol, as appropriate to national context, based on a set of indicators included in the comprehensive global monitoring framework for noncommunicable diseases and in line with the global strategy to reduce the harmful use of alcohol and its monitoring and reporting mechanisms, and developing further technical tools to support monitoring of agreed indicators of harmful use of alcohol and strengthening of national monitoring systems, as well as epidemiological research on alcohol and public health in Member States.

Actions for the Secretariat: tobacco control, promoting healthy diet, physical activity and reducing the harmful use of alcohol

44. Actions envisaged for the Secretariat include:

(a) **Leading and convening:** Work with the Secretariat of the WHO FCTC and United Nations funds, programmes and agencies (see Appendix 4) to reduce modifiable risk factors at

the country level, including as part of integrating prevention of noncommunicable diseases into the United Nations Development Assistance Framework's design processes and implementation at the country level.

(b) **Technical cooperation:** Provide technical support to reduce modifiable risk factors including through implementing the WHO FCTC and its guidelines, and the WHO guidelines and global strategies for addressing modifiable risk factors and other health-promoting policy options including healthy workplace initiatives, health-promoting schools and other educational institutions, healthy-cities initiatives, health-sensitive urban development and social and environmental protection initiatives, for instance, through engagement of local or municipal councils and subregional groups.

(c) **Policy advice and dialogue:** Publish and disseminate guidance ("toolkits") on the implementation and evaluation of interventions at the country level for reducing the prevalence of tobacco use, promoting a healthy diet and physical activity and reducing the harmful use of alcohol.

(d) **Norms and standards:** Support the Conference of the Parties to the WHO FCTC, through the Convention Secretariat, in promoting effective implementation of the Convention, including through development of guidelines and protocols where appropriate; continue to build on existing efforts and develop normative guidance and technical tools to support the implementation of WHO's global strategies for addressing modifiable risk factors; further develop a common set of indicators and data collection tools for tracking modifiable risk factors in populations, including studying the feasibility of composite indicators for monitoring the harmful use of alcohol at different levels and strengthening instruments for monitoring risk factors such as tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity, as well as developing country capacity for data analysis, reporting and dissemination.

(e) **Knowledge generation:** Strengthen the evidence base and disseminate evidence to support policy interventions at the country level for reducing the prevalence of tobacco use, promoting a healthy diet and physical activity and reducing the harmful use of alcohol.

Proposed actions for international partners:

45. Strengthen international cooperation within the framework of North–South, South–South and triangular cooperation, and forge collaborative partnerships, as appropriate, to:

- Facilitate the implementation of the WHO FCTC, the global strategy to reduce harmful use of alcohol, the global strategy on diet, physical activity and health, the global strategy for infant and young child feeding, and the implementation of WHO's set of recommendations on the marketing of foods and non-alcoholic beverages to children, by supporting and participating in capacity strengthening, shaping the research agenda, development and implementation of technical guidance, and mobilizing financial support, as appropriate.

Objective 4. To strengthen and orient health systems to address the prevention and control of noncommunicable diseases and the underlying social determinants through people-centred primary health care and universal health coverage

46. The Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases recognizes the importance of universal health coverage, especially through primary health care and social protection mechanisms, to provide access to health services for all, in particular, to the poorest segments of the population (paragraph 45(n) of the Political

Declaration of the United Nations General Assembly High-level Meeting on the Prevention and Control of Non-communicable Diseases). For comprehensive care of noncommunicable diseases all people require access, without discrimination, to a nationally determined set of promotive, preventive, curative, rehabilitative and palliative basic health services. It must be ensured that the use of these services does not expose the users to financial hardship, including in cases of ensuring the continuity of care in the aftermath of emergencies and disasters. A strengthened health system directed towards addressing noncommunicable diseases should aim to improve health promotion, prevention, early detection, treatment and sustained management of people with or at high risk for cardiovascular disease, cancer, chronic respiratory disease, diabetes and other noncommunicable diseases (Appendix 3), in order to prevent complications, reduce the need for hospitalization and costly high-technology interventions and premature deaths. The health sector also needs to collaborate with other sectors and work in partnership to ensure social determinants are considered in service planning and provision within communities.

47. The actions outlined under this objective aim to strengthen the health system including the health workforce, set policy directions for moving towards universal health coverage and contribute to achieving the voluntary global targets listed below as well as the premature mortality target:

- At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes.
- An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases in both public and private facilities.
- A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances.

Policy options for Member States¹

48. It is proposed that, in accordance with their legislation, and as appropriate in view of their specific circumstances, Member States may select and undertake actions from among the policy options set out below:

- (a) **Leadership:** Policy options to strengthen effective governance and accountability include:
- Exercise responsibility and accountability in ensuring the availability of noncommunicable disease services within the context of overall health system strengthening.
 - Use participatory community-based approaches in designing, implementing, monitoring and evaluating inclusive noncommunicable disease programmes across the life course and continuum of care to enhance and promote response effectiveness and equity.
 - Integrate noncommunicable disease services into health sector reforms and/or plans for improving health systems' performance.
 - As appropriate, orient health systems towards addressing the impacts of social determinants of health, including through evidence-based interventions supported by universal health coverage.

¹ And, where applicable, regional economic integration organizations.

(b) **Financing:** Policy options to establish sustainable and equitable health financing include:

- Shift from reliance on user fees levied on ill people to the protection provided by pooling and prepayment, with inclusion of noncommunicable disease services.
- Make progress towards universal health coverage through a combination of domestic revenues and traditional and innovative financing, giving priority to financing a combination of cost-effective preventive, curative and palliative care interventions at different levels of care covering noncommunicable diseases and including co-morbidities (see Appendix 3).
- Develop local and national initiatives for financial risk protection and other forms of social protection (for example through health insurance, tax funding and cash transfers and the consideration of health savings accounts), covering prevention, treatment, rehabilitation and palliative care for all conditions including noncommunicable diseases and for all people including those not employed in the formal sector.

(c) **Expanded quality services coverage:** Policy options to improve efficiency, equity, coverage and quality of health services with a special focus on cardiovascular disease, cancer, chronic respiratory disease and diabetes and their risk factors, together with other noncommunicable diseases that may be domestic priorities, include:

- Strengthen and organize services, access and referral systems around close-to-user and people-centred networks of primary health care that are fully integrated with the secondary and tertiary care level of the health care delivery system, including quality rehabilitation, comprehensive palliative care and specialized ambulatory and inpatient care facilities.
- Enable all providers (including nongovernmental organizations, for-profit and not-for-profit providers) to address noncommunicable diseases equitably while safeguarding consumer protection and also harnessing the potential of a range of other services such as traditional and complementary medicine, prevention, rehabilitation, palliative care and social services to deal with such diseases.
- Improve the efficiency of service delivery and set national targets consistent with voluntary global targets for increasing the coverage of cost-effective, high-impact interventions to address cardiovascular disease, diabetes, cancer, and chronic respiratory disease in a phased manner (see Appendix 3), linking noncommunicable disease services with other disease-specific programmes, including those for mental health (See Appendix 1).
- Meet the needs for long-term care of people with noncommunicable chronic diseases, related disabilities and co-morbidities through innovative, effective and integrated models of care, connecting occupational health services and community health services/resources with primary health care and the rest of the health care delivery system.
- Establish quality assurance and continuous quality improvement systems for prevention and management of noncommunicable diseases with emphasis on primary health care, including the use of evidence-based guidelines, treatment protocols and tools for the management of major noncommunicable diseases, risk factors and co-morbidities, adapted to national contexts.

- Take action to empower people with noncommunicable diseases to seek early detection and manage their own condition better, and provide education, incentives and tools for self-care and self-management, based on evidence-based guidelines, patient registries and team-based patient management including through information and communication technologies such as eHealth or mHealth.
- Review existing programmes, such as those on nutrition, HIV, tuberculosis, reproductive health, maternal and child health and mental health including dementia, for opportunities to integrate them into service delivery for the prevention and control of noncommunicable diseases.

(d) **Human resource development:** Policy options to strengthen human resources for the prevention and control of noncommunicable diseases include:

- Identify competencies required and invest in improving the knowledge, skills and motivation of the current health workforce to address noncommunicable diseases, including common co-morbid conditions (for example mental disorders) and plan to address projected health workforce needs for the future, including in the light of population ageing.
- Incorporate the prevention and control of noncommunicable diseases in the training of all health personnel including community health workers, social workers, professional and non-professional (technical, vocational) staff, with an emphasis on primary health care.
- Provide adequate compensation and incentives for health workers to serve underserved areas including location, infrastructure, training and development and social support.
- Promote the production, training and retention of health workers with a view to facilitating adequate deployment of a skilled workforce within countries and regions in accordance with the WHO Global Code of Practice on the International Recruitment of Health Personnel.¹
- Develop career tracks for health workers through strengthening postgraduate training, with a special focus on noncommunicable diseases, in various professional disciplines (for example, medicine, allied health sciences, nursing, pharmacy, public health administration, nutrition, health economics, social work and medical education) and enhancing career advancement for non-professional staff.
- Optimize the scope of nurses' and allied health professionals' practice to contribute to prevention and control of noncommunicable diseases, including addressing barriers to that contribution.
- Strengthen capacities for planning, implementing, monitoring and evaluating service delivery for noncommunicable diseases through government, public and private academic institutions, professional associations, patients' organizations and self-care platforms.

¹ See resolution WHA63.16.

(e) **Access:** Policy options to improve equitable access to prevention programmes (such as those providing health information) and services, essential medicines and technologies, with emphasis on medicines and technologies required for delivery of essential interventions for cardiovascular disease, cancer, chronic respiratory disease and diabetes, through a primary health care approach, include:

- Promote access to comprehensive and cost-effective prevention, treatment and care for the integrated management of noncommunicable diseases, including, inter alia, increased access to affordable, safe, effective and quality medicines and diagnostics and other technologies, including through the full use of trade-related aspects of intellectual property rights (TRIPS) flexibilities.
- Adopt evidence-informed country-based strategies to improve patient access to affordable medicines (for example, by including relevant medicines in national essential medicines lists, separating prescribing and dispensing, controlling wholesale and retail mark-ups through regressive mark-up schemes, and exempting medicines required for essential noncommunicable disease interventions from import and other forms of tax, where appropriate, within the national context).
- Promote procurement and use of safe, quality, efficacious and affordable medicines, including generics, for prevention and control of noncommunicable diseases, including access to medicines for alleviation of pain for palliative care and vaccinations against infection-associated cancers, through measures including quality assurance of medical products, preferential or accelerated registration procedures, generic substitution, preferential use of the international non-proprietary names, financial incentives where appropriate and education of prescribers and consumers.
- Improve the availability of life-saving technologies and essential medicines for managing noncommunicable diseases in the initial phase of emergency response.
- Facilitate access to preventive measures, treatment and vocational rehabilitation, as well as financial compensation for occupational noncommunicable diseases, consistent with international and national laws and regulations on occupational diseases.

Actions for the Secretariat

49. Actions envisaged for the Secretariat include:

(a) **Leading and convening:** Position the response to noncommunicable diseases at the forefront of efforts to strengthen health systems and achieve universal health coverage.

(b) **Technical cooperation:**

- Provide support, guidance and technical background to countries in integrating cost-effective interventions for noncommunicable diseases and their risk factors into health systems, including essential primary health care packages.
- Encourage countries to improve access to cost-effective prevention, treatment and care including, inter alia, increased availability of affordable, safe, effective and quality medicines and diagnostics and other technologies in line with the global strategy and plan of action on public health, innovation and intellectual property.

- Deploy an interagency emergency health kit for treatment of noncommunicable diseases in humanitarian disasters and emergencies.

(c) **Policy advice and dialogue:** Provide health policy guidance, in accordance with its mandate, using existing strategies that have been the subject of resolutions adopted by the World Health Assembly to advance the agenda for people-centred primary health care and universal health coverage.

(d) **Norms and standards:** Develop guidelines, tools and training materials (i) to strengthen the implementation of cost-effective noncommunicable disease interventions for early detection, treatment, rehabilitation and palliative care; (ii) to establish diagnostic and exposure criteria for early detection, prevention and control of occupational noncommunicable diseases; (iii) to facilitate affordable, evidence-based, patient/family-centred self-care with a special focus on populations with low health awareness and/or literacy, including the use of information and communication technologies (ICT), such as the Internet/mobile phone technologies, for the prevention and control of noncommunicable diseases, including health education, health promotion and communication for all groups.¹

(e) **Dissemination of evidence and best practices:** Provide further evidence on the effectiveness of different approaches to structured integrated care programmes for noncommunicable diseases and facilitate exchange of lessons, experiences and best practices, adding to the global body of evidence which will enhance the capacity of countries to face challenges and sustain achievements, as well as to develop new solutions to address noncommunicable diseases and progressively to implement universal health coverage.

Proposed actions for international partners

50. Strengthen international cooperation within the framework of North–South, South–South and triangular cooperation and forge collaborative partnerships, as appropriate, to:

(a) Facilitate the mobilization of adequate, predictable and sustained financial resources to advance universal coverage in national health systems, especially through primary health care further to facilitate quality and affordable secondary/tertiary health care and treatment facilities and social protection mechanisms, in order to provide access to health services for all, in particular for the poorest segments of the population.

(b) Support national authorities in strengthening health systems and expanding quality service coverage including through development of appropriate health care infrastructure and institutional capacity for training of health personnel such as public health institutions, medical and nursing schools.

(c) Contribute to efforts to improve access to affordable, safe, effective and quality medicines and diagnostics and other technologies, including through the full use of trade-related aspects of intellectual property rights flexibilities and provisions.

(d) Support national efforts for prevention and control of noncommunicable diseases, inter alia through the exchange of information on best practices and dissemination of findings in health systems research.

¹The Secretariat will continue to implement the ITU/WHO Global Joint Programme on mHealth and noncommunicable diseases.

Objective 5. To promote and support national capacity for high-quality research and development for the prevention and control of noncommunicable diseases

51. Although effective interventions exist for the prevention and control of noncommunicable diseases, their implementation is inadequate worldwide. Comparative, applied and operational research, integrating both social and biomedical sciences, is required to scale up and maximize the impact of existing interventions (see Appendix 3), in order to meet the nine voluntary global targets (see Appendix 2).

52. The Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases calls upon all stakeholders to support and facilitate research related to the prevention and control of noncommunicable diseases, and its translation into practice, so as to enhance the knowledge base for national, regional and global action. The global strategy and plan of action on public health, innovation and intellectual property (WHA61.21), encourages needs-driven research to target diseases that disproportionately affect people in low-income and middle-income countries, including noncommunicable diseases. WHO's prioritized research agenda for the prevention and control of noncommunicable diseases drawn up through a participatory and consultative process provides guidance on future investment in noncommunicable disease research.¹ The agenda prioritizes (i) research for placing noncommunicable diseases in the global development agenda and for monitoring; (ii) research to understand and influence the multisectoral, macroeconomic and social determinants of noncommunicable diseases and risk factors; (iii) translation and health systems research for global application of proven cost-effective strategies; and (iv) research to enable expensive but effective interventions to become accessible and be appropriately used in resource-constrained settings.

Policy options for Member States²

53. It is proposed that, in accordance with their legislation, and as appropriate in view of their specific circumstances Member States may select and undertake actions from among the policy options set out below.

(a) **Investment:** Increase investment in research, innovation and development and its governance as an integral part of the national response to noncommunicable diseases; in particular, allocate budgets to promote relevant research to fill gaps around the interventions in Appendix 3 in terms of their scalability, impact and effectiveness.

(b) **National research policy and plans:** Develop, implement and monitor in collaboration with academic and research institutions, as appropriate, a national policy and plan on noncommunicable-disease-related research including community-based research and evaluation of the impact of interventions and policies.

(c) **Capacity strengthening:** Strengthen national institutional capacity for research and development, including research infrastructure, equipment and supplies in research institutions, and the competence of researchers to conduct quality research.

(d) **Innovation:** Make more effective use of academic institutions and multidisciplinary agencies to promote research, retain research workforce, incentivize innovation and encourage the establishment of national reference centres and networks to conduct policy-relevant research.

¹ A prioritized research agenda for prevention and control of noncommunicable diseases. Geneva, World Health Organization, 2011.

² And, where applicable, regional economic integration organizations.

(e) **Evidence to inform policy:** Strengthen the scientific basis for decision-making through noncommunicable-disease-related research and its translation to enhance the knowledge base for ongoing national action.

(f) **Accountability for progress:** Track the domestic and international resource flows for research and national research output and impact applicable to the prevention and control of noncommunicable diseases.

Actions for the Secretariat

54. Actions envisaged for the Secretariat include:

(a) **Leading and convening:** Engage WHO collaborating centres, academic institutions, research organizations and alliances to strengthen capacity for research on noncommunicable diseases at the country level based on key areas identified in WHO's prioritized research agenda, promoting in particular research designed to improve understanding of affordability, implementation capacity, feasibility and impact on health equity of interventions and policy options contained in Appendix 3.

(b) **Technical cooperation:** Provide technical support upon request to strengthen national and regional capacity: (i) to incorporate research, development and innovation in national and regional policies and plans on noncommunicable diseases; (ii) to adopt and advance WHO's prioritized research agenda on the prevention and control of noncommunicable diseases, taking into consideration national needs and contexts; and (iii) to formulate research and development plans, enhance innovation capacities to support the prevention and control of noncommunicable diseases.

(c) **Policy advice and dialogue:** Promote sharing of intercountry research expertise and experience and publish/disseminate guidance ("toolkits") on how to strengthen links among policy, practice and products of research on prevention and control of noncommunicable diseases.

Proposed actions for international partners

55. Strengthen North–South, South–South and triangular cooperation and forge collaborative partnerships, as appropriate, to:

- Promote investment and strengthen national capacity for quality research, development and innovation, for all aspects related to the prevention and control of noncommunicable diseases in a sustainable and cost-effective manner, including through strengthening of institutional capacity and creation of research fellowships and scholarships.
- Facilitate noncommunicable-disease-related research and its translation to enhance the knowledge base for implementation of national, regional and global action plans.
- Promote the use of information and communications technology to improve programme implementation, health outcomes, health promotion, monitoring and reporting and surveillance systems and to disseminate, as appropriate, information on affordable, cost-effective, sustainable and quality interventions, best practices and lessons learnt in the field of noncommunicable diseases.
- Support countries and the Secretariat in implementing other actions set out in this objective.

Objective 6. To monitor the trends and determinants of noncommunicable diseases and evaluate progress in their prevention and control

56. The actions listed under this objective will support the monitoring of global and national progress in the prevention and control of noncommunicable diseases, using the global monitoring framework consisting of 25 indicators and nine voluntary global targets (see Appendix 2). Monitoring will provide internationally comparable assessments of the trends in noncommunicable diseases over time, help to benchmark the situation in individual countries against others in the same region or development category, provide the foundation for advocacy, policy development and coordinated action and help to reinforce political commitment.

57. In addition to the indicators outlined in the framework, countries and regions may include others to monitor progress of national and regional strategies for the prevention and control of noncommunicable diseases, taking into account country- and region-specific situations.

58. Financial and technical support will need to increase significantly for institutional strengthening in order to conduct surveillance and monitoring, taking account of innovations and new technologies that may increase effectiveness in collection and improve data quality and coverage, in order to strengthen capacity of countries to collect, analyse and communicate data for surveillance and global and national monitoring.

Policy options for Member States¹

59. It is proposed that, in accordance with their legislation, and as appropriate in view of their specific circumstances, Member States may select and undertake actions from among the policy options set out below:

(a) **Monitoring:** Update legislation pertaining to collection of health statistics, strengthen vital registration and cause of death registration systems, define and adopt a set of national targets and indicators based on the global monitoring framework and integrate monitoring systems for the prevention and control of noncommunicable diseases, including prevalence of relevant key interventions into national health information systems, in order systematically to assess progress in use and impact of interventions.

(b) **Disease registries:** Develop, maintain and strengthen disease registries, including for cancer, if feasible and sustainable, with appropriate indicators for better understanding of regional and national needs.

(c) **Surveillance:** Identify data sets, sources of data and integrate surveillance into national health information systems and undertake periodic data collection on the behavioural and metabolic risk factors (harmful use of alcohol, physical inactivity, tobacco use, unhealthy diet, overweight and obesity, raised blood pressure, raised blood glucose, and hyperlipidemia), and determinants of risk exposure such as marketing of food, tobacco and alcohol, with disaggregation of the data, where available, by key dimensions of equity, including gender, age (e.g. children, adolescents, adults) and socioeconomic status in order to monitor trends and measure progress in addressing inequalities.

(d) **Capacity strengthening and innovation:** Strengthen technical and institutional capacity including through establishment of public health institutes, to manage and implement

¹ And, where applicable, regional economic integration organizations.

surveillance and monitoring systems that are integrated into existing health information systems, with a focus on capacity for data management, analysis and reporting in order to improve availability of high-quality data on noncommunicable diseases and risk factors.

(e) **Dissemination and use of results:** Contribute, on a routine basis, information on trends in noncommunicable diseases with respect to morbidity, mortality by cause, risk factors and other determinants, disaggregated by age, gender, disability and socioeconomic groups and provide information to WHO on progress made in the implementation of national action plans and on effectiveness of national policies and strategies, coordinating country reporting with global analyses.

(f) **Budgetary allocation:** Increase and prioritize budgetary allocations for surveillance and monitoring systems for the prevention and control of noncommunicable diseases.

Actions for the Secretariat

60. Actions envisaged for the Secretariat include:

(a) Technical cooperation: Provide support to Member States to:

- Establish or strengthen national surveillance and monitoring systems, including improving collection of data on risk factors and other determinants, morbidity and mortality, and national responses for the prevention and control of noncommunicable diseases, for example through the development of standard modules, where appropriate, within household surveys.
- Develop national targets and indicators based on national situations, taking into account the global monitoring framework, including its indicators, and a set of voluntary global targets.

(b) Set standards and monitor global trends, capacity and progress in achieving the voluntary global targets:

- Develop appropriate action plan indicators as soon as possible, to monitor progress of implementation of the action plan.
- Develop, maintain and review standards for measurement of noncommunicable disease risk factors.
- Undertake periodic assessments of Member States' national capacity to prevent and control noncommunicable diseases.
- Provide guidance on definitions, as appropriate, and on how indicators should be measured, collected, aggregated and reported, as well as the health information system requirements at national level needed to achieve that.
- Review global progress made in the prevention and control of noncommunicable diseases, through monitoring and reporting on the attainment of the voluntary global targets in 2015 and 2020, so that countries can share knowledge of accelerators of progress and identify and remove impediments to attaining the global voluntary targets.

- Monitor global trends in noncommunicable diseases and their risk factors, and country capacity to respond, and publish periodic progress reports outlining the global status of the prevention and control of noncommunicable diseases, aligning such reporting with the 2015 and 2020 reporting within the global monitoring framework, and publish risk-factor-specific reports such as on the global tobacco epidemic or on alcohol and health.
- Convene a representative group of stakeholders, including Member States and international partners, in order to evaluate progress on implementation of this action plan at the mid-point of the plan's time frame and at the end of the period. The mid-term evaluation will offer an opportunity to learn from the experience of the first four years of the plan, taking corrective measures where actions have not been effective, and to reorient parts of the plan, as appropriate, in response to the post-2015 development agenda.

Proposed actions for international partners

61. Strengthen North–South, South–South and triangular cooperation and forge collaborative partnerships, as appropriate, to:

- Mobilize resources, promote investment and strengthen national capacity for surveillance, monitoring and evaluation, on all aspects of prevention and control of noncommunicable diseases.
- Facilitate surveillance and monitoring and the translation of results to provide the basis for advocacy, policy development and coordinated action and to reinforce political commitment.
- Promote the use of information and communications technology to improve capacity for surveillance and monitoring and to disseminate, as appropriate, data on trends in risk factors, determinants and noncommunicable diseases.
- Provide support for the other actions set out for Member States and the Secretariat under objective 6 for monitoring and evaluating progress in prevention and control of noncommunicable diseases at the national, regional and global levels.

Appendix 1

Synergies between major noncommunicable diseases and other conditions

A comprehensive response for prevention and control of noncommunicable diseases should take cognizance of a number of other conditions. Examples of these include cognitive impairment and other noncommunicable diseases, including renal, endocrin, neurological including epilepsy, autism, Alzheimer's and Parkinson's diseases, haematological including haemoglobinopathies (e.g. thalassaemia and sickle cell anaemia), hepatic, gastroenterological, musculoskeletal, skin and oral diseases, disabilities and genetic disorders that may affect individuals either alone or as co-morbidities. The presence of these conditions may also influence the development, progression and response to treatment of major noncommunicable diseases and should be addressed through integrated approaches. Further, conditions such as kidney disease result from lack of early detection and management of hypertension and diabetes, and therefore are closely linked to major noncommunicable diseases.

Other modifiable risk factors

Four main shared risk factors – tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol – are the most important in the sphere of noncommunicable diseases.

Exposure to environmental and occupational hazards, such as indoor and outdoor air pollution, with fumes from solid fuels, ozone, airborne dust and allergens may cause chronic respiratory disease and some air pollution sources including fumes from solid fuels may cause lung cancer, indoor and outdoor air pollution, heat waves and chronic stress related to work and unemployment are also associated with cardiovascular diseases. Exposure to carcinogens such as asbestos, diesel exhaust gases and ionizing and ultraviolet radiation in the living and working environment can increase the risk of cancer. Similarly, indiscriminate use of agrochemicals in agriculture and discharge of toxic products from unregulated chemical industries may cause cancer and other noncommunicable diseases such as kidney disease. These exposures have their greatest potential to influence noncommunicable diseases early in life, and thus special attention must be paid to preventing exposure during pregnancy and childhood.

Simple, affordable interventions to reduce environmental and occupational health risks are available, and prioritization and implementation of these interventions can contribute to reducing the burden due to noncommunicable diseases (relevant World Health Assembly resolutions include resolution WHA49.12 on WHO global strategy for occupational health for all, resolution WHA58.22 on cancer prevention and control, resolution WHA60.26 on workers' health – global plan of action, and resolution WHA61.19 on climate change and health).

Mental disorders

As mental disorders are an important cause of morbidity and contribute to the global burden of noncommunicable diseases, equitable access to effective programmes and health care interventions is needed. Mental disorders affect, and are affected by, other noncommunicable diseases: they can be a precursor or consequence of a noncommunicable disease, or the result of interactive effects. For example, there is evidence that depression predisposes people to heart attacks and, conversely, heart attacks increase the likelihood of depression. Risk factors of noncommunicable diseases such as sedentary behaviour and harmful use of alcohol also link noncommunicable diseases with mental disorders. Close connections with characteristics of economically underprivileged population segments such as lower educational level, lower socioeconomic status, stress and unemployment are shared by mental disorders and noncommunicable diseases. Despite these strong connections, evidence indicates that mental disorders in patients with noncommunicable diseases as well as

noncommunicable diseases in patients with mental disorders are often overlooked. The comprehensive mental health action plan needs to be implemented in close coordination with the action plan for the prevention and control of noncommunicable diseases, at all levels.

Communicable diseases

The role of infectious agents in the pathogenesis of noncommunicable diseases, either on their own or in combination with genetic and environmental influences, has been increasingly recognized in recent years. Many noncommunicable diseases including cardiovascular disease and chronic respiratory disease are linked to communicable diseases in either aetiology or susceptibility to severe outcomes. Increasingly cancers, including some with global impact such as cancer of the cervix, liver, oral cavity and stomach, have been shown to have an infectious aetiology. In developing countries, infections are known to be the cause of about one fifth of cancers. High rates of other cancers in developing countries that are linked to infections or infestations include herpes virus and HIV, in Kaposi sarcoma, and liver flukes, in cholangiocarcinoma. Some significant disabilities such as blindness, deafness, cardiac defects and intellectual impairment can derive from preventable infectious causes. Strong population-based services to control infectious diseases through prevention, including immunization (e.g. vaccines against hepatitis B, human papillomavirus, measles, rubella, influenza, pertussis, and poliomyelitis), diagnosis, treatment and control strategies will reduce both the burden and the impact of noncommunicable diseases.

There is also a high risk of infectious disease acquisition and susceptibility in people with pre-existing noncommunicable diseases. Attention to this interaction would maximize the opportunities to detect and to treat both noncommunicable and infectious diseases through alert primary and more specialized health care services. For example, tobacco smokers and people with diabetes, alcohol-use disorders, immunosuppression or exposure to second-hand smoke have a higher risk of developing tuberculosis. As the diagnosis of tuberculosis is often missed in people with chronic respiratory diseases, collaboration in screening for diabetes and chronic respiratory disease in tuberculosis clinics and for tuberculosis in noncommunicable disease clinics could enhance case-finding. Likewise, integrating noncommunicable disease programmes or palliative care with HIV care programmes would bring mutual benefits since both cater to long-term care and support as a part of the programme and also because noncommunicable diseases can be a side-effect of long-term treatment of HIV infection and AIDS.

Demographic change and disabilities

The prevention of noncommunicable diseases will increase the number and proportion of people who age healthily and avoid high health care costs and even higher indirect costs in older age groups. About 15% of the population experiences disability, and the increase in noncommunicable diseases is having a profound effect on disability trends; for example, these diseases are estimated to account for about two thirds of all years lived with disability in low-income and middle-income countries. Noncommunicable-disease-related disability (such as amputation, blindness or paralysis) puts significant demands on social welfare and health systems, lowers productivity and impoverishes families. Rehabilitation needs to be a central health strategy in noncommunicable disease programmes in order to address risk factors (e.g. obesity and physical inactivity), as well as loss of function due to noncommunicable diseases (e.g. amputation and blindness due to diabetes or stroke). Access to rehabilitation services can decrease the effects and consequences of disease, hasten discharge from hospital, slow or halt deterioration in health and improve quality of life.

Violence and unintentional injuries

Exposure to child maltreatment (which includes physical, sexual, and emotional abuse, and neglect or deprivation), is a recognized risk factor for the subsequent adoption of high-risk behaviours such as

smoking, harmful use of alcohol, drug abuse, and eating disorders, which in turn predispose individuals to noncommunicable diseases. There is evidence that ischaemic heart disease, cancer and chronic lung disease are related to experiences of abuse during childhood. Similarly, experiencing intimate partner violence has been associated with harmful use of alcohol and drug abuse, smoking, and eating disorders. Programmes to prevent child maltreatment and intimate partner violence can therefore make a significant contribution to the prevention of noncommunicable diseases by reducing the likelihood of tobacco use, unhealthy diet, and harmful use of alcohol.

The lack of safe infrastructure for people to walk and cycle is an inhibitor for physical exercise. Therefore, well-known road traffic injury prevention strategies such as appropriate road safety legislation and enforcement, as well as good land use planning and infrastructure supporting safe walking and cycling, can contribute to the prevention of noncommunicable diseases as well as help address injuries. Impairment by alcohol is an important factor influencing both the risks and the severity of all unintentional injuries. These include road traffic accidents, falls, drowning, burns and all forms of violence. Therefore, addressing harmful use of alcohol will be beneficial for prevention of noncommunicable diseases as well as injuries.

Appendix 2

Comprehensive global monitoring framework, including 25 indicators, and a set of nine voluntary global targets for the prevention and control of noncommunicable diseases

Framework element	Target	Indicator
Mortality and morbidity		
Premature mortality from noncommunicable disease	(1) A 25% relative reduction in the overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases	(1) Unconditional probability of dying between ages of 30 and 70 from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases
Additional indicator		(2) Cancer incidence, by type of cancer, per 100 000 population
Risk factors		
Behavioural risk factors		
Harmful use of alcohol ¹	(2) At least 10% relative reduction in the harmful use of alcohol, ² as appropriate, within the national context	(3) Total (recorded and unrecorded) alcohol per capita (aged 15+ years old) consumption within a calendar year in litres of pure alcohol, as appropriate, within the national context (4) Age-standardized prevalence of heavy episodic drinking among adolescents and adults, as appropriate, within the national context (5) Alcohol-related morbidity and mortality among adolescents and adults, as appropriate, within the national context
Physical inactivity	(3) A 10% relative reduction in prevalence of insufficient physical activity	(6) Prevalence of insufficiently physically active adolescents, defined as less than 60 minutes of moderate to vigorous intensity activity daily (7) Age-standardized prevalence of insufficiently physically active persons aged 18+ years (defined as less than 150 minutes of moderate-intensity activity per week, or equivalent)
Salt/sodium intake	(4) A 30% relative reduction in mean population intake of salt/sodium ³	(8) Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years
Tobacco use	(5) A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years	(9) Prevalence of current tobacco use among adolescents (10) Age-standardized prevalence of current tobacco use among persons aged 18+ years
Biological risk factors		
Raised blood pressure	(6) A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances	(11) Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic blood pressure \geq 140 mmHg and/or diastolic blood pressure \geq 90 mmHg) and mean systolic blood pressure
Diabetes and obesity ⁴	(7) Halt the rise in diabetes and obesity	(12) Age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years (defined as fasting plasma glucose concentration \geq 7.0 mmol/l (126 mg/dl) or on medication for raised blood glucose) (13) Prevalence of overweight and obesity in adolescents (defined according to the WHO growth reference for school-aged children and adolescents, overweight – one standard deviation body mass index for age and sex, and obese – two standard deviations body mass index for age and sex)

¹ Countries will select indicator(s) of harmful use as appropriate to national context and in line with WHO's global strategy to reduce the harmful use of alcohol and that may include prevalence of heavy episodic drinking, total alcohol per capita consumption, and alcohol-related morbidity and mortality, among others.

² In WHO's global strategy to reduce the harmful use of alcohol the concept of the harmful use of alcohol encompasses the drinking that causes detrimental health and social consequences for the drinker, the people around the drinker and society at large, as well as the patterns of drinking that are associated with increased risk of adverse health outcomes.

³ WHO's recommendation is less than 5 grams of salt or 2 grams of sodium per person per day.

⁴ Countries will select indicator(s) appropriate to national context.

Framework element	Target	Indicator
		(14) Age-standardized prevalence of overweight and obesity in persons aged 18+ years (defined as body mass index ≥ 25 kg/m ² for overweight and body mass index ≥ 30 kg/m ² for obesity)
Additional indicators		(15) Age-standardized mean proportion of total energy intake from saturated fatty acids in persons aged 18+ years ¹ (16) Age-standardized prevalence of persons (aged 18+ years) consuming less than five total servings (400 grams) of fruit and vegetables per day (17) Age-standardized prevalence of raised total cholesterol among persons aged 18+ years (defined as total cholesterol ≥ 5.0 mmol/l or 190 mg/dl); and mean total cholesterol concentration
National systems response		
Drug therapy to prevent heart attacks and strokes	(8) At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes	(18) Proportion of eligible persons (defined as aged 40 years and older with a 10-year cardiovascular risk $\geq 30\%$, including those with existing cardiovascular disease) receiving drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes
Essential noncommunicable disease medicines and basic technologies to treat major noncommunicable diseases	(9) An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases in both public and private facilities	(19) Availability and affordability of quality, safe and efficacious essential noncommunicable disease medicines, including generics, and basic technologies in both public and private facilities
Additional indicators		(20) Access to palliative care assessed by morphine-equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer (21) Adoption of national policies that limit saturated fatty acids and virtually eliminate partially hydrogenated vegetable oils in the food supply, as appropriate, within the national context and national programmes (22) Availability, as appropriate, if cost-effective and affordable, of vaccines against human papillomavirus, according to national programmes and policies (23) Policies to reduce the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, <i>trans</i> -fatty acids, free sugars, or salt (24) Vaccination coverage against hepatitis B virus monitored by number of third doses of Hep-B vaccine (HepB3) administered to infants (25) Proportion of women between the ages of 30–49 screened for cervical cancer at least once, or more often, and for lower or higher age groups according to national programmes or policies

¹ Individual fatty acids within the broad classification of saturated fatty acids have unique biological properties and health effects that can have relevance in developing dietary recommendations.

Appendix 3

The table below presents a menu of policy options and cost-effective interventions for prevention and control of major noncommunicable diseases, to support Member States in implementing, as appropriate for national context (without prejudice to the sovereign rights of nations to determine taxation among other policies), actions to achieve the nine voluntary global targets. (The information will need updating as the evidence and cost-effectiveness of interventions evolve with time.)

The list that follows is not exhaustive but is intended to provide information and guidance on effectiveness and cost-effectiveness^{1,2,3} of interventions based on current evidence and to act as the basis for future work to develop and expand the evidence base on policy measures and individual interventions. According to WHO estimates, policy interventions in objective 3 and individual interventions to be implemented in primary care settings in objective 4, listed in bold, are very cost-effective⁴ and affordable for all countries.^{1,2,3} However, they have not been assessed for specific contexts of individual countries. When selecting interventions for prevention and control of noncommunicable diseases, consideration should be given to effectiveness, cost-effectiveness, affordability, implementation capacity, feasibility, according to national circumstances, and impact on health equity of interventions, and to the need to implement a combination of population-wide policy interventions and individual interventions.

Menu of policy options	Voluntary global targets	WHO tools
<p>Objective 1</p> <ul style="list-style-type: none"> • Raise public and political awareness, understanding and practice about prevention and control of NCDs • Integrate NCDs into the social and development agenda and poverty alleviation strategies • Strengthen international cooperation for resource mobilization, capacity building, health workforce training and exchange of information on lessons learnt and best practices • Engage and mobilize civil society and the private sector as appropriate and strengthen international cooperation to support implementation of the action plan at global, regional and national levels • Implement other policy options in objective 1 (see paragraph 21) 	<p>Contribute to all 9 voluntary global targets</p>	<ul style="list-style-type: none"> – WHO global status report on NCDs 2010 – WHO fact sheets – Global atlas on cardiovascular disease prevention and control 2011 – IARC GLOBOCAN 2008 – Existing regional and national tools – Other relevant tools on WHO website including resolutions and documents of WHO governing bodies and regional committees

¹ Scaling up action against noncommunicable diseases: How much will it cost? Geneva, World Health Organization, 2011.

² WHO-CHOICE refers to “Choosing Interventions that are Cost Effective”.

³ The International Bank for Reconstruction and Development/The World Bank, Disease control priorities in developing countries. Washington, DC, Oxford University Press and The World Bank, 2006.

⁴ Very cost-effective, i.e. generate an extra year of healthy life for a cost that falls below the average annual income or gross domestic product per person.

Menu of policy options	Voluntary global targets	WHO tools
<p>Objective 2</p> <ul style="list-style-type: none"> • Prioritize and increase, as needed, budgetary allocations for prevention and control of NCDs, without prejudice to the sovereign right of nations to determine taxation and other policies • Assess national capacity for prevention and control of NCDs • Develop and implement a national multisectoral policy and plan for the prevention and control of NCDs through multistakeholder engagement • Implement other policy options in objective 2 (see paragraph 30) to strengthen national capacity including human and institutional capacity, leadership, governance, multisectoral action and partnerships for prevention and control of noncommunicable diseases 	<p>Contribute to all 9 voluntary global targets</p>	<ul style="list-style-type: none"> – United Nations Secretary-General's Note A/67/373 – NCD country capacity survey tool – NCCP Core Capacity Assessment tool – Existing regional and national tools – Other relevant tools on WHO website including resolutions and documents of WHO governing bodies and regional committees
<p>Objective 3¹</p> <p>Tobacco use²</p> <ul style="list-style-type: none"> • Implement WHO FCTC (see paragraph 36). Parties to the WHO FCTC are required to implement all obligations under the treaty in full; all Member States that are not Parties are encouraged to look to the WHO FCTC as the foundational instrument in global tobacco control • Reduce affordability of tobacco products by increasing tobacco excise taxes³ • Create by law completely smoke-free environments in all indoor workplaces, public places and public transport³ • Warn people of the dangers of tobacco and tobacco smoke through effective health warnings and mass media campaigns³ • Ban all forms of tobacco advertising, promotion and sponsorship³ 	<p>A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years</p> <p>At least a 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context</p> <p>A 10% relative reduction in prevalence of insufficient physical activity</p>	<ul style="list-style-type: none"> – The WHO FCTC and its guidelines – MPOWER capacity-building modules to reduce demand for tobacco, in line with the WHO FCTC – WHO reports on the global tobacco epidemic – Recommendations on the marketing of foods and non-alcoholic beverages to children (WHA63.14) – Global strategy on diet, physical activity and health (WHA57.17)

¹ In addressing each risk factor, Member States should not rely on one single intervention, but should have a comprehensive approach to achieve desired results.

² Tobacco use: Each of these measures reflects one or more provisions of the WHO Framework Convention on Tobacco Control (WHO FCTC). The measures included in this Appendix are not intended to suggest a prioritization of obligations under the WHO FCTC. Rather, these measures have been proven to be feasible, affordable and cost-effective and are intended to fulfil the criteria established in the chapeau paragraph of Appendix 3 for supporting countries in their efforts to meet the agreed targets as quickly as possible. The WHO FCTC includes a number of other important provisions, including supply-reduction measures and those to support multisectoral action, which are part of any comprehensive tobacco control programme.

Some interventions for management of noncommunicable diseases that are cost-effective in high-income settings, which assume a cost-effective infrastructure for diagnosis and referral and an adequate volume of cases, are not listed under objective 4, e.g. pacemaker implants for atrioventricular heart block, defibrillators in emergency vehicles, coronary revascularization procedures, and carotid endarterectomy.

³ Very cost-effective i.e. generate an extra year of healthy life for a cost that falls below the average annual income or gross domestic product per person.

Menu of policy options	Voluntary global targets	WHO tools
<ul style="list-style-type: none"> • Reduce salt intake^{1,2} • Replace trans fats with unsaturated fats¹ • Implement public awareness programmes on diet and physical activity¹ • Replace saturated fat with unsaturated fat • Manage food taxes and subsidies to promote healthy diet • Implement other policy options listed in objective 3 for addressing unhealthy diet and physical inactivity 	<p>prevalence of raised blood pressure according to national circumstances</p> <p>Halt the rise in diabetes and obesity</p>	
<p>Objective 4</p> <ul style="list-style-type: none"> • Integrate very cost-effective noncommunicable disease interventions into the basic primary health care package with referral systems to all levels of care to advance the universal health coverage agenda • Explore viable health financing mechanisms and innovative economic tools supported by evidence • Scale up early detection and coverage, prioritizing very cost-effective high-impact interventions including cost-effective interventions to address behavioural risk factors • Train health workforce and strengthen capacity of health system particularly at primary care level to address the prevention and control of noncommunicable diseases • Improve availability of affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases, in both public and private facilities • Implement other cost-effective interventions and policy options in objective 4 (see paragraph 47) to strengthen and orient health systems to address noncommunicable diseases and risk factors through people-centred primary health care and universal health coverage • Develop and implement a palliative care policy using cost-effective treatment modalities, including opioids analgesics for pain relief and training health workers <p>Cardiovascular disease and diabetes³</p> <ul style="list-style-type: none"> • Drug therapy (including glycaemic control for diabetes mellitus and control of hypertension using a total risk approach) and counselling to individuals who have had a heart attack or stroke and to persons with high risk (≥ 30%) of a fatal and nonfatal cardiovascular event in the next 10 years¹ 	<p>An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases in both public and private facilities</p> <p>At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes</p>	<ul style="list-style-type: none"> – World health reports 2010, 2011 – Prevention and control of noncommunicable diseases: Guidelines for primary health care in low-resource settings; diagnosis and management of type 2 diabetes and Management of asthma and chronic obstructive pulmonary disease 2012 – Guideline for cervical cancer: Use of cryotherapy for cervical intraepithelial neoplasia – Guideline for pharmacological treatment of persisting pain in children with medical illnesses – Scaling up NCD interventions, WHO 2011 – WHO CHOICE database – WHO Package of essential noncommunicable (PEN) disease interventions for primary health care including costing tool 2011 – Prevention of cardiovascular disease. Guidelines for assessment and management of cardiovascular risk 2007 – Integrated clinical protocols for primary health care and WHO ISH cardiovascular risk prediction charts 2012

¹ Very cost-effective i.e. generate an extra year of healthy life for a cost that falls below the average annual income or gross domestic product per person.

² And adjust the iodine content of iodized salt, when relevant.

³ Policy actions for prevention of major noncommunicable diseases are listed under objective 3.

Menu of policy options	Voluntary global targets	WHO tools
<ul style="list-style-type: none"> • Acetylsalicylic acid for acute myocardial infarction¹ • Drug therapy (including glycaemic control for diabetes mellitus and control of hypertension using a total risk approach) and counselling to individuals who have had a heart attack or stroke, and to persons with moderate risk ($\geq 20\%$) of a fatal and nonfatal cardiovascular event in the next 10 years • Detection, treatment and control of hypertension and diabetes, using a total risk approach • Secondary prevention of rheumatic fever and rheumatic heart disease • Acetylsalicylic acid, atenolol and thrombolytic therapy (streptokinase) for acute myocardial infarction • Treatment of congestive cardiac failure with ACE inhibitor, beta-blocker and diuretic • Cardiac rehabilitation post myocardial infarction • Anticoagulation for medium- and high-risk non-valvular atrial fibrillation and for mitral stenosis with atrial fibrillation • Low-dose acetylsalicylic acid for ischaemic stroke <p>Diabetes²</p> <ul style="list-style-type: none"> • Lifestyle interventions for preventing type 2 diabetes • Influenza vaccination for patients with diabetes • Preconception care among women of reproductive age including patient education and intensive glucose management • Detection of diabetic retinopathy by dilated eye examination followed by appropriate laser photocoagulation therapy to prevent blindness • Effective angiotensin-converting enzyme inhibitor drug therapy to prevent progression of renal disease • Care of acute stroke and rehabilitation in stroke units • Interventions for foot care: educational programmes, access to appropriate footwear; multidisciplinary clinics <p>Cancer²</p> <ul style="list-style-type: none"> • Prevention of liver cancer through hepatitis B immunization¹ • Prevention of cervical cancer through screening (visual inspection with acetic acid [VIA] (or Pap smear (cervical cytology), if very cost-effective)¹ linked with timely treatment of pre-cancerous lesions¹ 	<p>A 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases</p> <p>A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances</p>	<ul style="list-style-type: none"> – Affordable technology: Blood pressure measurement devices for low-resource settings 2007 – Indoor air quality guidelines – WHO air quality guidelines for particular matter, ozone, nitrogen, dioxide and sulphur dioxide, 2005 – Cancer control: Modules on prevention and palliative care – Essential Medicines List (2011) – OneHealth tool – Enhancing nursing and midwifery capacity to contribute to the prevention, treatment and management of noncommunicable diseases – Existing regional and national tools – Other relevant tools on WHO website including resolutions and documents of WHO governing bodies and regional committees

¹ Very cost-effective, i.e. generate an extra year of healthy life for a cost that falls below the average annual income or gross domestic product per person.

² Policy actions for prevention of major noncommunicable diseases are listed under objective 3.

Menu of policy options	Voluntary global targets	WHO tools
<ul style="list-style-type: none"> • Vaccination against human papillomavirus, as appropriate if cost-effective and affordable, according to national programmes and policies • Population-based cervical cancer screening linked with timely treatment¹ • Population-based breast cancer and mammography screening (50–70 years) linked with timely treatment¹ • Population-based colorectal cancer screening, including through a fecal occult blood test, as appropriate, at age >50, linked with timely treatment¹ • Oral cancer screening in high-risk groups (e.g. tobacco users, betel-nut chewers) linked with timely treatment¹ <p>Chronic respiratory disease²</p> <ul style="list-style-type: none"> • Access to improved stoves and cleaner fuels to reduce indoor air pollution • Cost-effective interventions to prevent occupational lung diseases, e.g. from exposure to silica, asbestos • Treatment of asthma based on WHO guidelines • Influenza vaccination for patients with chronic obstructive pulmonary disease 		
<p>Objective 5</p> <ul style="list-style-type: none"> • Develop and implement a prioritized national research agenda for noncommunicable diseases • Prioritize budgetary allocation for research on noncommunicable disease prevention and control • Strengthen human resources and institutional capacity for research • Strengthen research capacity through cooperation with foreign and domestic research institutes • Implement other policy options in objective 5 (see paragraph 53) to promote and support national capacity for high-quality research, development and innovation 	Contribute to all 9 voluntary global targets	<ul style="list-style-type: none"> – Prioritized research agenda for the prevention and control of noncommunicable diseases 2011 – World Health Report 2013 – Global strategy and plan of action on public health, innovation and intellectual property (WHA61.21) – Existing regional and national tools – Other relevant tools on WHO website including resolutions and documents of WHO governing bodies and regional committees
<p>Objective 6</p> <ul style="list-style-type: none"> • Develop national targets and indicators based on global monitoring framework and linked with a multisectoral policy and plan • Strengthen human resources and institutional capacity for surveillance and monitoring and evaluation 	Contribute to all 9 voluntary global targets	<ul style="list-style-type: none"> – Global monitoring framework – Verbal autopsy instrument – STEPwise approach to surveillance – Global Tobacco Surveillance System

¹ Screening is meaningful only if associated with capacity for diagnosis, referral and treatment.

² Policy actions for prevention of major noncommunicable diseases are listed under objective 3.

Menu of policy options	Voluntary global targets	WHO tools
<ul style="list-style-type: none"> • Establish and/or strengthen a comprehensive noncommunicable disease surveillance system, including reliable registration of deaths by cause, cancer registration, periodic data collection on risk factors, and monitoring national response • Integrate noncommunicable disease surveillance and monitoring into national health information systems • Implement other policy options in objective 6 (see paragraph 59) to monitor trends and determinants of noncommunicable diseases and evaluate progress in their prevention and control 		<ul style="list-style-type: none"> – Global Information System on Alcohol and Health – Global school-based student health survey, ICD-10 training tool – Service Availability and Readiness (SARA) assessment tool – IARC GLOBOCAN 2008 – Existing regional and national tools – Other relevant tools on WHO website including resolutions and documents of WHO governing bodies and regional committees

Appendix 4¹**Examples of collaborative division of tasks and responsibilities**

Concerns a provisional list only. A division of labour is being developed by the United Nations Funds, programmes and agencies

UNDP	<ul style="list-style-type: none"> • Support non-health government departments in their efforts to engage in a multisectoral whole-of-government approach to noncommunicable diseases • Support ministries of planning in integrating noncommunicable diseases in the development agenda of each Member State • Support ministries of planning in integrating noncommunicable diseases explicitly into poverty-reduction strategies • Support national AIDS commissions in integrating interventions to address the harmful use of alcohol into existing national HIV programmes
UNECE	<ul style="list-style-type: none"> • Support the Transport, Health and Environment Pan-European Programme
UN-ENERGY	<ul style="list-style-type: none"> • Support global tracking of access to clean energy and its health impacts for the United Nations Sustainable Energy for All Initiative • Support the Global Alliance for Clean Cookstoves and the dissemination/tracking of clean energy solutions for households
UNEP	<ul style="list-style-type: none"> • Support the implementation of international environmental conventions
UNFPA	<ul style="list-style-type: none"> • Support health ministries in integrating noncommunicable diseases into existing reproductive health programmes, with a particular focus on (1) cervical cancer and (2) promoting healthy lifestyles among adolescents
UNICEF	<ul style="list-style-type: none"> • Strengthen the capacities of health ministries to reduce risk factors for noncommunicable diseases among children and adolescents • Strengthen the capacities of health ministries to tackle malnutrition and childhood obesity
UN-WOMEN	<ul style="list-style-type: none"> • Support ministries of women or social affairs in promoting gender-based approaches for the prevention and control of noncommunicable diseases
UNAIDS	<ul style="list-style-type: none"> • Support national AIDS commissions in integrating interventions for noncommunicable diseases into existing national HIV programmes • Support health ministries in strengthening chronic care for HIV and noncommunicable diseases (within the context of overall health system strengthening) • Support health ministries in integrating HIV and noncommunicable disease programmes, with a particular focus on primary health care
UNSCN	<ul style="list-style-type: none"> • Facilitate United Nations harmonization of action at country and global levels for the reduction of dietary risk of noncommunicable diseases • Disseminate data, information and good practices on the reduction of dietary risk of noncommunicable diseases • Integration of the action plan into food and nutrition-related plans, programmes and initiatives (for example, UNSCN's Scaling Up Nutrition, FAO's Committee on World Food Security, and the maternal, infant and young child nutrition programme of the Global Alliance for Improved Nutrition)

¹ This information will be updated periodically based on input provided by United Nations agencies.

IAEA	<ul style="list-style-type: none"> Expand support to health ministries to strengthen treatment components within national cancer control strategies, alongside reviews and projects of IAEA's Programme of Action for Cancer Therapy that promote comprehensive cancer control approaches to the implementation of radiation medicine programmes
ILO	<ul style="list-style-type: none"> Support WHO's global plan of action on workers' health, Global Occupational Health Network and the Workplace Wellness Alliance of the World Economic Forum Promote the implementation of international labour standards for occupational safety and health, particularly those regarding occupational cancer, asbestos, respiratory diseases and occupational health services
UNRWA	<ul style="list-style-type: none"> Strengthen preventive measures, screening, treatment and care for Palestine refugees living with noncommunicable diseases Improve access to affordable essential medicines for noncommunicable diseases through partnerships with pharmaceutical companies
WFP	<ul style="list-style-type: none"> Prevent nutrition-related noncommunicable diseases, including in crisis situations
ITU	<ul style="list-style-type: none"> Support ministries of information in including noncommunicable diseases in initiatives on information, communications and technology Support ministries of information in including noncommunicable diseases in girls' and women's initiatives Support ministries of information in the use of mobile phones to encourage healthy choices and warn people about tobacco use, including through the existing ITU/WHO Global Joint Programme on mHealth and noncommunicable diseases
FAO	<ul style="list-style-type: none"> Strengthen the capacity of ministries of agriculture in redressing food insecurity, malnutrition and obesity Support ministries of agriculture in aligning agricultural, trade and health policies
WTO	<ul style="list-style-type: none"> Operating within the scope of its mandate, support ministries of trade in coordination with other competent government departments (especially those concerned with public health), to address the interface between trade policies and public health issues in the area of noncommunicable diseases
UN-HABITAT	<ul style="list-style-type: none"> Support ministries of housing in addressing noncommunicable diseases in a context of rapid urbanization
UNESCO	<ul style="list-style-type: none"> Support the education sector in considering schools as settings to promote interventions to reduce the main shared modifiable risk factors for noncommunicable diseases Support the creation of programmes related to advocacy and community mobilization for the prevention and control of noncommunicable diseases using the media and world information networks Improve literacy among journalists to enable informed reporting on issues impacting the prevention and control of noncommunicable diseases
UNOSDP	<ul style="list-style-type: none"> Promote the use of sport as a means to the prevention and control of noncommunicable diseases
WIPO	<ul style="list-style-type: none"> Operating within the scope of its mandate, support, upon request, relevant ministries and national institutions to address the interface between public health, innovation and intellectual property in the area of noncommunicable diseases
UNODC	To be further explored ¹
INCB	To be further explored ¹

¹ Including through the planned ECOSOC discussion on the UN taskforce.

Appendix 5

Examples of cross-sectoral government engagement to reduce risk factors, and potential health effects of multisectoral action¹

Sector	Tobacco	Physical inactivity	Harmful use of alcohol	Unhealthy diet
Agriculture	✓		✓	✓
Communication	✓	✓	✓	✓
Education	✓	✓	✓	✓
Employment	✓	✓	✓	✓
Energy		✓	✓	✓
Environment	✓	✓	✓	✓
Finance	✓	✓	✓	✓
Food/catering	✓	✓	✓	✓
Foreign affairs	✓	✓	✓	✓
Health	✓	✓	✓	✓
Housing	✓	✓		✓
Justice/security	✓	✓	✓	✓
Legislature	✓	✓	✓	✓
Social welfare	✓	✓	✓	✓
Social and economic development	✓	✓	✓	✓
Sports	✓	✓	✓	✓
Tax and revenue	✓	✓	✓	✓
Trade and industry (excluding tobacco industry)	✓	✓	✓	✓
Transport	✓	✓	✓	✓
Urban planning	✓	✓	✓	✓
Youth affairs	✓	✓	✓	✓

¹ The table has been adapted from United Nations General Assembly document A/67/373.

Examples of potential health effects of multisectoral action¹

	Tobacco	Physical inactivity	Harmful use of alcohol	Unhealthy diet
Sectors involved (examples)	<ul style="list-style-type: none"> Legislature Stakeholder ministries across government, including ministries of agriculture, customs/revenue, economy, education, finance, health, foreign affairs, labour, planning, social welfare, state media, statistics and trade 	<ul style="list-style-type: none"> Ministries of education, finance, labour, planning, transport, urban planning, sports, and youth Local government 	<ul style="list-style-type: none"> Legislature Ministries of trade, industry, education, finance and justice, Local government 	<ul style="list-style-type: none"> Legislature Ministries of trade, agriculture, industry, education, urban planning, energy, transport, social welfare and environment Local government
Examples of multisectoral action	<ul style="list-style-type: none"> Full implementation of WHO Framework Convention on Tobacco Control obligations through coordination committees at the national and subnational levels 	<ul style="list-style-type: none"> Urban planning/re-engineering for active transport and walkable cities School-based programmes to support physical activity Incentives for workplace healthy-lifestyle programmes Increased availability of safe environments and recreational spaces Mass media campaigns Economic interventions to promote physical activity (taxes on motorized transport, subsidies on bicycles and sports equipment) 	<ul style="list-style-type: none"> Full implementation of the WHO global strategy to reduce the harmful use of alcohol 	<ul style="list-style-type: none"> Reduced amounts of salt, saturated fat and sugars in processed foods Limit saturated fatty acids and eliminate industrially produced trans fats in foods Controlled advertising of unhealthy food to children Increase availability and affordability of fruit and vegetables to promote intake Offer of healthy food in schools and other public institutions and through social support programmes Economic interventions to drive food consumption (taxes, subsidies) Food security
Desired outcome	<ul style="list-style-type: none"> Reduced tobacco use and consumption, including secondhand smoke exposure and reduced production of tobacco and tobacco products 	<ul style="list-style-type: none"> Decreased physical inactivity 	<ul style="list-style-type: none"> Reduced harmful use of alcohol 	<ul style="list-style-type: none"> Reduced use of salt, saturated fat and sugars Substitution of healthy foods for energy-dense micronutrient-poor foods

¹ With the involvement of civil society and the private sector, as appropriate.

ANNEX 5

Agreement between the World Health Organization and the South Centre

[A66/46, Annex – 14 May 2013]

The World Health Organization (hereinafter referred to as “WHO”), on the one hand; and

The South Centre, on the other hand;

Hereinafter separately and collectively respectively referred to as the “Party” and the “Parties”

Considering that the objective of WHO is the attainment by all peoples of the highest possible level of health and that in order to achieve that objective WHO acts as the directing and coordinating authority on international health matters;

Further considering that the South Centre is an intergovernmental organization of developing countries created out of the work and experience of the South Commission including its report “The Challenge to the South” with the aim of promoting policy advice and cooperation among developing countries in their effort to achieve sustainable economic development;

Recalling that the South Centre has the status of observer in the United Nations General Assembly by resolution 63/131 of 15 January 2009, which affirms the important role of the South Centre in supporting the work of the United Nations and its agencies;

Further recalling that WHO and the South Centre cooperate on some issues relating to health and development, including access to medicines and other health technologies, and research and development into medicines and other health technologies;

Aware of the emergence of dynamic challenges for developing countries in which the convergence of interests and complementarity of the Parties could, while maintaining intellectual independence, reinforce their work in support of the main challenges facing the developing world;

Wishing to coordinate their efforts within the framework of the mandates assigned to them and in accordance with the provisions of WHO’s Constitution and with the Agreement to Establish the South Centre;

Desirous of strengthening their cooperation on the basis of regular consultations;

Have agreed as follows:

Article 1

Purpose of this Agreement

This Agreement shall govern the relations between WHO and the South Centre.

Article 2

Objectives and areas of cooperation

1. The objective of this Agreement is to strengthen cooperation between WHO and the South Centre in all matters arising in the field of health that are connected with the activities and commitments of the two Organizations, including access to medicines and other health technologies.
2. WHO and the South Centre reaffirm, in accordance with their respective mandates and with their respective rules, policies and practices, their complementary commitments to serve the needs of their respective Member States and partner countries through all appropriate means, including by: research activities, information collection and dissemination, and the convening of meetings of representatives of their Member States and other relevant stakeholders.
3. Cooperation between the Parties shall respect the differences in institutional and operational arrangements governing their action, their core competencies and comparative advantages in order to make their collaboration in the field of health complementary and mutually reinforcing.

Article 3

Financial aspects and joint resource mobilization

1. This Agreement defines in general terms the basis for cooperation but does not constitute a financial obligation to serve as a basis for expenditures.
2. To the extent that any activity may give rise to a legal or financial obligation, a separate agreement shall be concluded subject to the respective financial regulations and rules of the South Centre and WHO, prior to such activity being undertaken.

Article 4

Reciprocal representation

1. On the basis of reciprocity, the South Centre shall be invited to be represented at sessions of the World Health Assembly, and, as may be agreed to be appropriate, such other meetings held under the auspices of WHO as are of interest to the South Centre, and to participate without the right to vote in their deliberations on items on their agenda in which the South Centre has an interest.
2. On the basis of reciprocity, the World Health Organization shall be invited to be represented at meetings of the Council of Representatives of the South Centre, and, as may be agreed to be appropriate, such other meetings held under the auspices of the South Centre as are of interest to the World Health Organization, and to participate without the right to vote in their deliberations on items on their agenda in which WHO has an interest.

Article 5

Exchange of information

1. The WHO and the South Centre shall exchange information relating to activities on subjects of common interest, subject to any measures which might be necessary to safeguard requirements of confidentiality or privilege.

2. Such exchanges shall be supplemented, as necessary, by consultations at the request of the other Party with respect to matters arising in relation to this Agreement.

Article 6

Privileges and Immunities

Nothing in this Agreement may be interpreted or construed as a waiver or a modification of the privileges and/or immunities, which WHO and the South Centre enjoy by virtue of the international agreements and national laws applicable to the organizations.

Article 7

Entry into force, modification and termination

1. The present Agreement shall enter into force on the date on which it is signed by the Director-General of WHO and the Executive Director of the South Centre, subject to the approval of the World Health Assembly and by the Board of the South Centre.
2. This Agreement may be modified by mutual consent expressed in writing. It may also be terminated by either Party giving six months' notice to the other Party.
3. In the event of termination of the Agreement, the Parties shall take all necessary steps to ensure that such a decision is not prejudicial to any activities under implementation within the framework of the present Agreement.

Article 8

Dispute settlement

Any dispute, controversy, or claim that may arise over the interpretation or application of this Agreement shall be settled amicably by negotiation between the Parties. Should attempts at amicable negotiation fail, any such dispute shall, upon request by either Party, be referred to the arbitration in accordance with the United Nations Commission on International Trade Law (UNCITRAL) Arbitration Rules in force.

IN FAITH WHEREOF the present Agreement was done and signed at _____ on _____ in two copies both in English.

For the South Centre

For the World Health Organization

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

Not applicable. The implementation of the action plan will commence in 2014.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

Not applicable.

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

2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)

Strategic objective(s): all

Organization-wide expected result(s): all

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

This resolution contributes to the achievement of the Organization-wide expected results in communicable diseases, noncommunicable diseases, health through the life-course, health systems strengthening and preparedness, surveillance, and response.

Does the programme budget already include the products or services requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) One year (covering the period mid-2013 to mid-2014)

(ii) Total: US\$ 8.34 million (staff and activities)

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).

Total: US\$ 4.87 million (staff and activities)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

The activities will be primarily implemented through the WHO Office in Jerusalem, which is responsible for WHO’s cooperation programme with the Palestinian Authority. WHO’s activities in the field will be supplemented by support from the Regional Office for the Eastern Mediterranean, and by the headquarters clusters involved in work on poliomyelitis, emergencies and country cooperation, and by those working on health security and the environment.

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

Yes.

If “no”, indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

Yes.

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

Funding gap: US\$ 1.59 million; source(s) of funds: funding will continue to be sought through voluntary contributions, including the Consolidated Appeal Process; critical funding gaps may in part be closed through assessed contributions.

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

2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)

Strategic objective(s): 4 and 11

Organization-wide expected result(s): 4.7, 11.1, 11.2, 11.3

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

Implementation of the resolution would support Member States to improve the quality, supply and use of life-saving commodities for women’s and children’s health, and to take the necessary actions for reducing maternal and child mortality and achieving Millennium Development Goals 4 and 5.

Does the programme budget already include the products or services requested in this resolution? (Yes/no)

Additional resources will be required to support work on prequalification, quality assurance, demand creation and for other actions identified for implementing recommendations of the Commission, particularly in relation to technical support by WHO.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Three years (covering the period 2013–2015)

(ii) Total: US\$ 20 million (staff: US\$ 6 million; activities: US\$ 14 million)

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).

Total: US\$ 5.83 million (staff: US\$ 830 000; activities: US\$ 5.00 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

No.

If “no”, indicate how much is not included.

US\$ 5.83 million

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No.

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

Headquarters: one staff member at grade P.5, one at grade P.4 and one at grade P.3, each post requiring skills in commodity management and quality assurance.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

There is a funding gap of US\$ 5.83 million (US\$ 2.60 million pledged, source of funds: Norway via the secretariat of the United Nations Commission on Life-Saving Commodities for Women and Children; US\$ 3.23 million, source of funds: mobilization strategy pending).

1. Resolution WHA66.8 Comprehensive mental health action plan 2013–2020

2. Linkage to programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)

Strategic objective: 3

Organization-wide expected result(s): 3.1, 3.2, 3.3, 3.4, 3.5 and 3.6

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

The resolution is linked to the six expected results listed above and their indicators, including: the number of Member States with a mental health budget of more than 1% of the total health budget; number of Member States that have initiated the process of developing a mental health policy or law; number of low- and middle-income Member States with basic mental health indicators annually reported; and the availability of evidence-based guidance on the effectiveness of interventions for the management of selected mental, behavioural or neurological disorders including those due to use of psychoactive substances.

Does the Programme budget already include the products or services requested in this resolution? (Yes/no)

No.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(iii) Eight years (covering the period 2013–2020)

(ii) Total US\$ 97 million (staff: US\$ 37 million; activities: US\$ 60 million)

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).

Total US\$ 6 million (staff: US\$ 2 million; activities: US\$ 4 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Headquarters: 26%; regional level: 20%; and country level: 54%

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

No.

If “no”, indicate how much is not included.

US\$ 1.4 million (25% of the estimated cost)

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no).

No.

If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

Five additional staff (100% full-time equivalent) and one additional staff (50% full-time equivalent) would be required at headquarters (four international experts in public health and mental disorders, one secretary and one 50% full-time equivalent staff member for work on financial matters).

Six additional staff would be required in the six WHO regions (six international experts in public health, mental disorders with knowledge of the respective regional needs).

Eighteen additional staff would be required in the 18 countries of the six WHO regions (18 local experts in mental disorders and in the related national and subregional needs).

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 1.5 million would need to be mobilized to cover implementation during the second half of 2013 through Member States, multilateral organizations and other partners.

1. Resolution WHA66.9 Disability

**2. Linkage to the Programme budget 2012–2013 (see document A64/7
http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)**

Strategic objective(s): 3

Organization-wide expected result(s): 3.1, 3.3 and 3.6

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

It links with existing Organization-wide expected results.

Does the programme budget already include the products or services requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget**(a) Total cost**

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Five years (covering the period 2013–2017)

(ii) Total: US\$ 30 million (staff: US\$ 15 million; activities: US\$ 15 million)

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).

Total: US\$ 2.4 million (staff: US\$ 1.2 million; activities: US\$ 1.2 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

All levels of the Organization.

Is the estimated cost fully included within the approved Programme budget 2012–2013?

(Yes/no)

Yes.

If "no", indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No. Additional staff are required in four regional offices and at headquarters. The staff will be recruited in the next biennium.

If "no" indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

In the regional offices for Africa, South-East Asia, Europe and the Eastern Mediterranean one additional full-time staff member per regional office is required to act as a focal point.

Two technical officers are required at headquarters to develop a rehabilitation programme, including assistive technology provision, disability-inclusive health system strengthening and data collection.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No: 80% of funds are available.

If "no", indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 480 000; source(s) of funds: a number of donors have been approached to support, including USAID and CBM International. Discussions are continuing.

1. Resolution 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. Linkage to the Programme budget 2012–2013 (see document A64/7
http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)

Strategic objective(s): 3, 6 and 9

Organization-wide expected result(s): 3.1, 3.2, 3.3, 3.4, 3.6, 6.1, 6.2, 6.3, 6.4, 6.5, 9.1, 9.3 and 9.4

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

The WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020 includes a comprehensive set of policy options and actions for all stakeholders. These are presented under six objectives that, if effectively implemented, will: prevent and reduce disease, disability and premature death (Organization-wide expected result 3); promote health and development, and prevent or reduce risk factors (Organization-wide expected result 6); and improve nutrition, throughout the life-course, and support public health and sustainable development (Organization-wide expected result 9).

Does the Programme budget already include the products or services requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget**(a) Total cost**

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Eight years, covering the period 2013–2020

(ii) US\$ 75 million (2013), US\$ 192 million (2014–2015), US\$ 230 million (2016–2017), US\$ 276 million (2018–2019) and US\$ 165 million (2020)

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).

US\$ 75 million (staff: US\$ 45 million; activities: US\$ 30 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

At the three levels of the Organization.

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

Yes.

If “no”, indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No.

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

Staffing at the three levels of the Organization needs to be scaled up. Posts that are currently vacant need to be filled.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 30 million would be required to complete continuing activities for the full implementation of the action plan for the global strategy for the prevention and control of noncommunicable diseases (endorsed by the Health Assembly in resolution WHA61.14), covering the period 2008–2013. This figure includes US\$ 10 million for critical work in 2013 to enable the Organization to start delivering the activities included in the global action plan for the prevention and control of noncommunicable diseases 2013–2020.

1. Resolution WHA66.18 Follow-up of the report of the Working Group on the Election of the Director-General of the World Health Organization

2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)

Strategic objective(s): 12

Organization-wide expected result(s): 12.1

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

It links with existing Organization-wide expected results.

Does the programme budget already include the products or services requested in this resolution? (Yes/no)

No.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Every five years (beginning in the biennium 2016–2017)

(ii) Total: US\$ 70 936 (staff: US\$ nil; activities: US\$ 70 936)

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).

Total: US\$ nil (staff: US\$ nil; activities: US\$ nil)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Headquarters

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

No, it will be included within the Programme budget 2016–2017. The financial period 2012–2013 is not concerned by this resolution.

If “no”, indicate how much is not included.

Not applicable.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

Yes.

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

Not applicable.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

Not applicable.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

Yes, but re-allocation of funding may be required for one-time office start-up and operating costs.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

Not applicable.

1. Resolution WHA66.23 Transforming health workforce education in support of universal health coverage**2. Linkage to programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)**

Strategic objective(s): 10
(Category 4 in Programme budget
2014–2015)

Organization-wide expected result(s): 10.9
(Outcome 4.2, output 4.2.2 for Programme budget 2014–
2015)

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

The resolution relates to activities on integrated people-centred health services under category 4 of the Twelfth General Programme of Work. For the Programme budget 2014–2015, implementation of the resolution would fall under outcome 4.2 and output 4.2.2: “Countries enabled to plan and implement strategies that are in line with WHO’s global strategy on human resources for health and the WHO Global Code of Practice on the International Recruitment of Health Personnel”. The resolution covers the period 2013–2017 and activities are included in the approved Programme budget 2014–2015. Implementation of the resolution should lead to an increase in the number of countries that have an investment plan for scaling up and/or improving the training and education of health workers in accordance with national health needs. This will involve an assessment of current practices, and guidance and collaboration to transform education systems in support of a better response to people’s health needs.

Does the Programme budget already include the products or services requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget**(a) Total cost**

Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Five years (covering the period 2013–2017)

(ii) Total: US\$ 5.5 million (staff: US\$ 3.3 million; activities: US\$ 2.2 million)

The relevant programme budgets include US\$ 0.6 million for the biennium 2012–2013 and US\$ 3.1 million for the biennium 2014–2015. The funding for implementation in the biennium 2014–2015, will come from a combination of assessed and voluntary contributions, generated during the financing dialogue and the follow-up resource mobilization.

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).

Total: US\$ 600 000 (staff: US\$ 200 000; activities: US\$ 400 000)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Headquarters and the six regional offices.

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

Yes.

If “no”, indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no).

No. Additional staff would be needed at headquarters and in the regional offices to implement the following activities:

- adapting and field testing the assessment tool and guidelines
- providing technical support to Member States
- organizing regional training and monitoring meetings
- developing global and regional approaches, which may include strategies for the transformative education of health professionals.

If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

One additional full-time equivalent staff member would be required at the global level to adapt tools and develop approaches, and to coordinate and monitor regional activities. In addition, one full-time staff member would be required at the Regional Office for Africa and five staff members (60% full-time equivalent) would be required, one in each of the other regional offices, with skills in health professional education and health systems. These staffing needs are for the biennium 2014–2015. During the biennium 2016–2017 the staffing requirement would be halved; it would be evenly distributed across headquarters and the regional offices.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No, the current funding available, US\$ 100 000, only covers part of the staffing requirements. Funding is needed to review and adapt the current tool, field test it in collaboration with four Member States, and organize two technical consultations (one before and one after the field testing). A technical expert will need to be brought in to support the Secretariat team.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 0.5 million; source(s) of funds: external, international donors.

1. Resolution WHA66.24 eHealth standardization and interoperability

2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)

Strategic objective(s): 10

Organization-wide expected result(s): 10.7

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

It would strengthen country health information systems by supporting the provision of timely, reliable, and accurate data for decision-making.

Does the programme budget already include the products or services requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Five years (covering the period 2013–2017)

(ii) Total: US\$ 2.25 million (staff: US\$ 750 000; activities: US\$ 1.50 million)

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).

Total: US\$ 250 000 (staff: US\$ 200 000; activities: US\$ 50 000)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

All levels of the Organization.

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

Yes.

If “no”, indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No.

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

One staff member (50% full-time equivalent).

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

Yes.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

Not applicable.