The “Unofficial” WHCA Action Guide to the:

WHO—65th
World Health Assembly

MAY 2012, GENEVA
The “Unofficial” World Health Communication Associates (WHCA) Action Guide to the:

WHO - 65th World Health Assembly

21-26 May 2012, Geneva
Introduction

This “unofficial” WHCA Action Guide is a compilation of information from the WHO website regarding the 65th World Health Assembly. It is presented for use by World Health Communication Associates and World Health Editors Network (WHEN) members only and is not intended for sale or general circulation. It includes useful information regarding the Assembly, including texts of key discussion papers and resolutions. It serves as a one-stop-shop background document for WHEN journalists covering the WHA, 21-26 May 2012 in Geneva.

A big thank you to WHCA Associates Carinne Allinson for the compilation and Tuuli Sauren for the editing and design of this document. We would also like to thank World Health Professions Alliance (WHPA see http://www.whpa.org/) and the International Alliance of Patients’ Organisations (IAPO) for commentaries included with permission in this Guide.

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The World Health Communication Associates (WHCA) works to improve health by helping public health advocates and organisations acquire the knowledge, savvy and resources to enable their messages to stand out and positively shape health choices, behaviours and perceptions in local, national and global information marketplaces. WHCA focuses exclusively on health and environmental issues and does no product promotion. The Associates are an independent network of active, strategically-placed communicators, with practical experience in health and environment reporting, investigative journalism, policy advocacy, intergovernmental and non-governmental public and press relations, international conference organisation and cross-border campaigning.

The World Health Editors Network (WHEN) is an international, inter-professional exchange and action platform dedicated to exploring and strengthening communications as a positive determinant of health. Through participation in events, editors get early access to global health news and experts and importantly, key international health agency agenda-setting intelligence. WHEN development is being facilitated by the World Health Professional Alliance and its constituent association members, including the International Council of Nurses (ICN), the International Pharmaceutical Federation (FIP), the FDI World Dental Federation, the World Medical Association (WMA) and the World Confederation of Physical Therapists. WHCA serve as Secretariat to WHEN.
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ANNEX 1. STRUCTURE OF WHO

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Section I: Introduction to WHO and the World Health Assembly
(Adapted from WHO website, www.who.int, accessed April 2012)

The World Health Organization (WHO) is the directing and coordinating authority for health within the United Nations’ system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.

WHO experts produce health guidelines and standards, and help countries to address public health issues. WHO also supports and promotes health research. Through WHO, governments can jointly tackle global health problems and improve people’s well-being. WHO’s Constitution came into force on 7 April 1948 — a date now celebrated every year as World Health Day.

WHO and its Member States work with many partners, including UN agencies, donors, nongovernmental organizations, WHO collaborating centres and the private sector.

World Health Assembly

The World Health Assembly is the supreme decision-making body for WHO. It meets each year in May in Geneva and is attended by delegations from all 193 Member States. Its main function is to determine the policies of the Organization. The Health Assembly appoints the Director-General, supervises the financial policies of the Organization, and reviews and approves the proposed programme budget. It similarly considers reports of the Executive Board, which it instructs in regard to matters upon which further action, study, investigation or report may be required.

All World Health Assembly documentation is available at http://apps.who.int/gb/.

Executive Board

The Executive Board is composed of 34 members technically qualified in the field of health. Members are elected for three-year terms. The main Board meeting, at which the agenda for the forthcoming Health Assembly is agreed upon and resolutions for forwarding to the Health Assembly are adopted, is held in January each year, with a second shorter meeting in May, immediately after the Health Assembly, for more administrative matters. The main functions of the Board are to give effect to the decisions and policies of the Health Assembly, to advise it and generally to facilitate its work.

All Executive Board documentation is available at http://apps.who.int/gb/.

WHO Staff

More than 8000 people from more than 150 countries work for the Organization in 147 country offices, six regional offices (see Annex 1) and at the headquarters in Geneva, Switzerland.

In addition to medical doctors, public health specialists, scientists and epidemiologists, WHO staff include people trained to manage administrative, financial, and information systems, as well as experts in the fields of health statistics, economics and emergency relief.
Regional Committees

The six WHO Regional Committees meet separately once every year to set policy and approve budgets and programmes of work for their respective regions. Each meeting addresses the specific public health needs of the area represented by the region.
Section II: Overview of the 65th World Health Assembly agenda and resolutions

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• Nutrition of women in the preconception period, during pregnancy and the breastfeeding period

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C. Global strategy and plan of action on public health, innovation and intellectual property (resolution WHA61.21)

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F. Chagas disease: control and elimination (resolution WHA63.20)

G. Viral hepatitis (resolution WHA63.18)

H. Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis (resolution WHA62.15)

I. Cholera: mechanisms for control and prevention (resolution WHA64.15)

J. Control of human African trypanosomiasis (resolution WHA57.2)

K. Global health sector strategy on HIV/AIDS, 2011-2015 (resolution WHA64.14)

L. Prevention and control of sexually transmitted infections: global strategy (resolution WHA59.19)
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N. Advancing food safety initiatives (resolution WHA63.3)
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Section III: Selected agenda discussion topics and resolutions(*)

13.1 Prevention and control of noncommunicable diseases*

Document A65/6 (Report by the Secretariat):

Outcomes of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control

1. In resolution WHA64.11, the Health Assembly requested the Director-General, inter alia, to report to the Sixty-fifth World Health Assembly, through the Executive Board, on the outcomes of two high-level meetings, namely: the first Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control (Moscow, 28 and 29 April 2011); and the High-level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases (New York, 19 and 20 September 2011). In response, and in line with the request included, inter alia, in United Nations General Assembly resolution 66/2, the Political Declaration of the High-level Meeting, the Director-General prepared a report that was considered by the Executive Board at its 130th session. Subsequently, the Board adopted resolution EB130.R7, which, inter alia, requests the Director-General to implement specific aspects of the Political Declaration and to report on that work to the Sixty-fifth World Health Assembly. The present document responds to the request in subparagraph 2(1)(e) to submit a substantive progress report on the development of a comprehensive global monitoring framework, including a set of indicators and voluntary global targets for the prevention and control of noncommunicable diseases.

2. Resolution EB130.R7 sets out a time frame for the actions required. The present report provides information on the process followed and its outputs as at 30 March 2012. A further report will be issued prior to the Health Assembly, giving an update on progress achieved.

Development Process

3. In line with the Political Declaration and in response to resolution EB130.R7, the process to develop a comprehensive global monitoring framework, including a set of indicators and voluntary global targets for the prevention and control of noncommunicable diseases has continued in an inclusive and transparent manner as set out below.

(a) WHO held a web-based consultation with Member States on a discussion paper on the monitoring framework, including a set of indicators and targets for the prevention and control of noncommunicable diseases. Twenty-one Member States submitted written comments to the consultation, which was organized between December 2011 and February 2012.

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1 See documents EB130/6 and EB130/2012/REC/2, summary record of the eighth and ninth meetings.
2 See document EB130/2012/REC/1 for the resolution, and for the financial and administrative implications for the Secretariat of the adoption of the resolution.
3 In addition, documents A65/7 and A65/7 Add.1 respond to the request, made to the Director-General in subparagraph 2(3) of resolution EB130.R7, to submit a progress report and a timeline for WHO’s input on options for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases through effective partnership.
4 Document A65/6 Add.1.
(b) An informal dialogue on a global monitoring framework and recommendations for a set of voluntary targets was held with nongovernmental organizations on 15 December 2011. Twenty-three nongovernmental organizations attended and provided feedback on the process and content of the discussion paper.

(c) An informal face-to-face consultation with Member States and United Nations agencies, funds and programmes was held on 9 January 2012. The consultation, which focused on the framework and the voluntary targets, was attended by 43 Member States and 11 bodies of the United Nations system.

(d) In early February 2012, a summary of discussions held during the consultation, including questions raised by Member States, was posted on the WHO web site.

(e) The WHO European Region held a regional technical consultation on surveillance, monitoring and evaluation for noncommunicable diseases. A summary of the discussions at the consultation, which was organized in Oslo on 9 and 10 February 2012, was made available for consideration by Member States of the European Region.

(f) A second draft discussion paper on the global monitoring framework and indicators, and on recommendations for a set of voluntary global targets has been prepared on the basis of the consultations mentioned above and guided by feedback from Member States.

(g) A second web-based consultation for Member States and United Nations agencies, funds and programmes will be held from 22 March 2012 to 19 April 2012 on the framework, indicators and targets. In line with resolution EB130.R7, nongovernmental organizations and the private sector will also be invited to give their views on the second discussion paper during this consultation.

(h) A second face-to-face consultation on the draft framework and indicators and targets will be held for Member States and United Nations agencies, funds and programmes on 26 and 27 April 2012. During this consultation the Secretariat will provide a summary of views on the second discussion paper received from nongovernmental organizations and the private sector during the second web-based consultation.

(i) A second informal dialogue with nongovernmental organizations on the second discussion paper will be held on 30 April 2012.

(j) An informal dialogue with the private sector on the second discussion paper is scheduled to be held on 2 May 2012.

(k) Member States will be invited to attend both the dialogues mentioned in subparagraphs (i) and (j) above.

(l) On the basis of the inputs received in response to the second discussion paper, during the web-based and face-to-face consultations, and during the informal dialogues with nongovernmental organizations and the private sector, the Secretariat will submit an addendum to the present substantive progress report for consideration by the Health Assembly.5

FRAMEWORK, INDICATORS AND TARGETS: STATUS OF DEVELOPMENT

4. The development of the global framework, including a set of indicators and targets, is described below. These continuing efforts are based on advice provided to the Secretariat by WHO’s epidemiology reference group, and the WHO Technical Working Group on Noncommunicable Disease Targets in 2010 and 2011, as well as input received from

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5 Document A65/6 Add.1.
Member States on the first discussion paper through the processes described above, and
guided by the relevant operative paragraphs of resolution EB130.R7.

5. In their feedback following the web-based and face-to-face consultations, Member
States have requested the Secretariat to: provide additional details on the criteria used
for selecting proposed targets and indicators; describe the link between the global
monitoring framework and its indicators and targets; provide information on the methods
used for the modelling exercise that underpinned the target-setting processes; strengthen
the equity dimension of the targets and indicators; provide more detail on the extent to
which the global targets and indicators are realistic; and provide a description of the
relationship between the global targets and indicators and any national target-setting
process. Member States also raised concerns about the suitability of some of the suggested
targets and indicators, while highlighting gaps, such as the need for indicators and/or
targets related to physical inactivity, additional dietary risk factors, and access to
medicines and diagnostics.

6. Feedback provided by relevant nongovernmental organizations during the informal
dialogue held on 15 December 2011 highlighted, among other things, the importance of
setting realistic targets, identifying targets and indicators that would hold governments
accountable, and including additional targets for areas such as access to medicines,
physical inactivity and dental caries, and specific targets for children.

7. The second revised WHO discussion paper outlines a global monitoring framework, and
a set of indicators for monitoring progress in preventing and reducing noncommunicable
diseases. The global monitoring framework is based on the recommended national
monitoring framework for the prevention and control of noncommunicable diseases, which
incorporates three main elements: (a) monitoring outcomes (morbidity and disease-
specific mortality); (b) monitoring exposures (risk factors); and (c) monitoring health
system responses. Core indicators (and any associated targets) within the framework must
be realistic, feasible and evidence-based. The second discussion paper also outlines draft
WHO recommendations for a set of voluntary global targets, with indicators and data
sources defined, to be achieved by 2025.

8. The global monitoring framework includes a group of core indicators, within which a
small set contains voluntary global targets.

9. The indicators and global targets were selected on the basis of the following criteria.
They had to: (a) be of significant epidemiological and public health relevance; (b)
maintain coherence with major global and regional strategies; (c) offer evidence-based,
effective and feasible public health interventions; (d) provide evidence of achievability at
the country level, including in low- and middle-income countries; and (e) offer data
collection instruments and the potential for a baseline to be established and changes
monitored over time.

10. In line with these criteria, and the comments received from Member States at the end
of February 2012, the second discussion paper proposes five global targets, which
comprise: a mortality target (25% relative reduction in overall mortality from
cardiovascular disease, cancer, diabetes or chronic respiratory disease) and four risk-
factor targets (reduced prevalence of hypertension/raised blood pressure, tobacco
smoking, physical inactivity and dietary salt intake).

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11. The global targets have been limited to a small number. They will provide a foundation for global monitoring needs, with a special emphasis on ensuring feasibility of application across regional and country settings. The mortality target is highly dependent on the extent to which the four risk-factor targets will be met along with progress on other key indicators for noncommunicable diseases. The global targets were established following a scientific review of the current situation and trends, and a critical assessment of feasibility. Where possible, the performance of the top 10% of countries over at least the last 10 years was used to set a target. The baseline year for monitoring progress is 2010 and the target year is 2025. The global targets are presented in terms of relative reduction between 2010 and 2025.

12. In addition to the indicators with global targets, the global monitoring framework also identifies a series of additional WHO core indicators that do not meet all criteria but which are considered to have a major impact on reducing noncommunicable diseases. This second group of indicators covers a broader array of conditions, risk factors and interventions. The indicators were selected primarily for their public health relevance and measurability. The suggested broad set of core indicators within the global monitoring framework is listed below; core indicators proposed as targets are also shown.

Core indicators for the surveillance of noncommunicable diseases

Outcomes

- Unconditional probability of death between the ages of 30 and 70 years from cardiovascular diseases, cancer, diabetes and chronic respiratory diseases (target).
- Cancer incidence, by type of cancer.

Risk exposures

- Age-standardized prevalence of current tobacco smoking among persons aged 15 years or more (target).
- Age-standardized prevalence of insufficiently active adults aged 18 years or more (defined as less than 150 minutes of moderate-intensity activity per week, or equivalent) (%) (target).
- Age-standardized mean intake of dietary sodium chloride per day among the adult population (those aged 18 years or more) (%) (target).
- Age-standardized prevalence of adult population (those aged 18 years or more) consuming less than five total servings (400 grams) of fruit and vegetables per day.
- Adult per capita consumption of pure alcohol (recorded and estimated unrecorded) (litres).
- Age-standardized prevalence of overweight and obesity in adults aged 18 years or more, adolescents and children (defined respectively as body mass index greater than
25 kg/m² for overweight and 30 kg/m² for obesity, and according to the WHO Growth Reference and WHO Child Growth Reference Standards (%)..

- Age-standardized prevalence of raised total cholesterol among adults aged 18 years or more (defined as total cholesterol = 5.0 mmol/l or 190 mg/dl).

**National health systems response**

- Adoption of national policies that eliminate partially hydrogenated vegetable oils in the food supply.
- Adoption of national policies to reduce the impact on children of marketing of foods high in saturated fats, trans-fatty acids, free sugars, or salt.
- Multidrug therapy (including glycaemic control) for people aged 30+ years with a 10-year risk of heart attack or stroke ≥ 30%, or existing cardiovascular disease.
- Prevalence of women between the ages of 30 and 49 years screened for cervical cancer at least once.
- Provision of vaccination against viruses associated with cancers: human papillomavirus and hepatitis B virus.
- Availability of generic essential medicines against noncommunicable diseases in both public and private facilities.
- Availability of selected essential basic diagnostics (devices for measuring blood glucose and blood pressure) for the screening of noncommunicable diseases in both public and private facilities.
- Access to palliative care assessed by morphine-equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer.

13. Global progress made should be reviewed every five years, that is, in 2015, 2020 and 2025. Intermediate targets can be set based on linear progress towards the 2025 targets. Reporting should balance country ownership and application against comparability and transparency so that lessons can be shared and progress measured. This would require country reporting to be closely coordinated with global analyses.

14. Robust monitoring systems will be needed at the country level. In accordance with paragraphs 45 and 60 of the Political Declaration, Member States should give greater priority to surveillance for the prevention and control of noncommunicable diseases, strengthen country-level surveillance and monitoring systems, and should increase and prioritize budgetary allocations for surveillance.

**National targets and indicators based on national situations**

15. In accordance with paragraph 63 of the Political Declaration, Member States are to consider the development of national targets and indicators for the prevention and control of noncommunicable diseases based on national situations, building on the guidance provided by WHO.

16. In this regard, the Secretariat will continue to provide technical assistance and capacity-building support to developing countries, especially least developed countries, so that they can strengthen country-level surveillance and monitoring systems, including improving their collection of data and statistics on risk factors, determinants and mortality through surveys that are integrated into existing national health information systems.
THE FUTURE

17. Paragraph 62 of the Political Declaration calls upon WHO, through the governing bodies, to prepare recommendations before the end of 2012 for a set of voluntary global targets for the prevention and control of noncommunicable diseases.

18. Resolution EB130.R7 requests the Director-General, inter alia, to complete the work on the global monitoring framework indicators and targets, based on a Member States consultation held before the end of 2012, and to report on the implementation of the recommendations relating to paragraphs 61 and 62 of the Political Declaration, through the Executive Board at its 132nd session, to the Sixty-sixth World Health Assembly.

19. In accordance with paragraph 45 of the Political Declaration, Member States should promote, establish or support and strengthen, by 2013, as appropriate, national policies and plans for the prevention and control of noncommunicable diseases.

20. Paragraph 64 of the Political Declaration requests the Secretary-General, in close collaboration with the Director-General of WHO, to submit by the end of 2012 to the General Assembly, at its sixty-seventh session, for consideration by Member States, options for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases through effective partnership. In this regard, the Secretariat has submitted to the Health Assembly a separate progress report and a timeline for WHO’s inputs to the report of the United Nations Secretary-General.7

21. Resolution EB130.R7 requests the Director-General, inter alia, to submit to the Sixty-sixth World Health Assembly, through the Executive Board, a WHO action plan for the prevention and control of noncommunicable diseases for 2013-2020, for consideration and possible adoption.

ACTION BY THE WORLD HEALTH ASSEMBLY

22. The Health Assembly is invited to note the report and to provide further guidance.

[DOCUMENTS A65/6 add. and A65/7 and A65.7 add. NEED TO BE INSERTED HERE]

Document A65/8 (Report by the Secretariat):

Implementation of the global strategy for the prevention and control of noncommunicable diseases and the action plan

1. At its 130th session in January 2012, the Executive Board noted an earlier version of this report.8

2. This report provides an overview of progress in implementing the action plan for the global strategy for the prevention and control of noncommunicable diseases9 that was endorsed by the Sixty-first World Health Assembly in May 2008 (resolution WHA61.14). As

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7 Document A65/7.
8 See documents EB130/7 and EB130/2012/REC/2, summary record of the eighth meeting.
9 Document WHA61/2008/REC/1, Annex 3.
the previous progress report covering the period 2008-2009 was considered by the Sixty-third World Health Assembly,10 the present report refers to the period 2010-2011.

3. The action plan has six objectives: (1) to raise the priority accorded to noncommunicable diseases in development work at global and national levels, and to integrate prevention and control of such diseases into policies across all government departments; (2) to establish and strengthen national policies and plans for the prevention and control of noncommunicable diseases; (3) to promote interventions to reduce the main shared modifiable risk factors for noncommunicable diseases: tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol; (4) to promote research for the prevention and control of noncommunicable diseases; (5) to promote partnerships for the prevention and control of noncommunicable diseases; and (6) to monitor noncommunicable diseases and their determinants and evaluate progress at the national, regional and global levels.

PROGRESS BY OBJECTIVE

OBJECTIVE 1. To raise the priority accorded to noncommunicable diseases in development work at global and national levels, and to integrate prevention and control of such diseases into policies across all government departments

4. Actions undertaken by the Secretariat include the following:

(a) The evidence linking noncommunicable diseases with socioeconomic development, poverty and the health-related Millennium Development Goals was reviewed. A summary of the findings was included in WHO’s Global status report on noncommunicable diseases 2010.11

(b) The Secretariat organized an expert consultation on Intersectoral action on health: impact on noncommunicable diseases through diet and physical activity (Helsinki, 6 and 7 September 2010) in order to review international experiences and lessons learnt. Global and regional workshops have been held on capacity strengthening for integration of noncommunicable disease interventions into primary care.

(c) As part of the preparatory process for the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases (New York, 19 and 20 September 2011), the Secretariat convened regional multisectoral consultations with the participation of Member States. Their purpose was: to review the magnitude of the burden and the socioeconomic impact of noncommunicable diseases; to discuss the political and policy relevance of tackling noncommunicable diseases in all countries; and to identify the challenges, opportunities and recommended actions for putting noncommunicable disease prevention and control on the development agenda.12

(d) At the WHO Global Forum on addressing the challenge of noncommunicable diseases (Moscow, 27 April 2011), a wide group of stakeholders identified, and committed themselves to, priority actions to produce results at the global level.13 The sharing of different perspectives helped to prepare for discussions at the subsequent ministerial conference.

10 See documents A63/12 and WHA63/2010/REC/3, summary records of the seventh, eighth and ninth meetings of Committee A.
(e) The outcomes of both the first Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control (Moscow, 28 and 29 April 2011; organized jointly by the Russian Federation and the Secretariat), and the High-level meeting of the United Nations General Assembly are summarized in a separate report to the Board.\textsuperscript{14} The Moscow Declaration presents the rationale for and commitment to action at the national and international levels.

(f) To effectively address noncommunicable diseases and their risk factors and social determinants, it will require a multisectoral action such as health in all policies and whole of government approaches. To facilitate country action and to improve the effectiveness of such action and approaches, models and methods are being developed through the 8th Global Conference on Health Promotion in Finland 2013, organized jointly by the Secretariat and the Ministry of Social Affairs and Health of the Government of Finland. The Conference Organizing Committee met in August 2011; the Memorandum of Understanding between Finland and WHO was signed by the Minister of Health and Social Services of Finland and the Director-General in October 2011.

**OBJECTIVE 2. To establish and strengthen national policies and plans for the prevention and control of noncommunicable diseases**

5. Actions undertaken by the Secretariat include the following:

(a) The Secretariat has supported the preparation of evidence-based guidance and simplified tools for the assessment and management of cardiovascular risk, early detection of cancer, and management of diabetes, asthma and chronic obstructive pulmonary disease in primary care in resource-constrained settings. It has also provided technical support to Member States to build national capacities to put noncommunicable disease interventions into practice through a primary health care approach.

(b) Five international seminars on the public health aspects of noncommunicable diseases were held in Switzerland for managers of national noncommunicable disease programmes in 2010 and 2011 in order to strengthen country capacities.

(c) To support the formulation and implementation of cost-effective prevention and control interventions in low- and middle-income countries, the Secretariat has issued clear position statements and comprehensive technical guidance on surveillance, prevention and management of noncommunicable diseases and on integration of a core set of effective and affordable interventions for the major diseases into health systems through a primary health care approach. A tool to estimate the resources needed and costs of expanding a core intervention package in low- and middle-income countries\textsuperscript{15} was also designed and disseminated to Member States.

(d) The effectiveness and core components of self-care models were systematically reviewed in order to provide the basis of recommendations for self-care and self-management of noncommunicable diseases.

(e) A training package has been prepared for facilitating the treatment of tobacco dependence in primary health care systems. Technical support was provided to eight countries for integrating brief tobacco interventions into their primary health care systems.

\textsuperscript{14} Document EB130/6.

\textsuperscript{15} Scaling up action against noncommunicable diseases: how much will it cost?, see http://www.who.int/nmh/publications/cost_of_inaction/en/ (accessed 28 February 2012).
OBJECTIVE 3. To promote interventions to reduce the main shared modifiable risk factors for noncommunicable diseases: tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol

6. Actions undertaken by the Secretariat include the following:

**Tobacco control**

(a) Technical support has been provided to Member States for implementing the WHO Framework Convention on Tobacco Control, including the measures intended to assist country-level implementation of the obligations in the Convention to reduce the demand for tobacco. Training packages relating to tobacco taxation, smoke-free environments, tobacco product packaging and labelling, imposing a comprehensive ban on tobacco advertising, promotion and sponsorship, and demand-reduction measures concerning tobacco dependence and cessation were developed and piloted. Technical support has been provided to 20 countries in implementing measures on demand reduction. Capacity assessments were conducted in nine low- and middle-income countries in order to identify strengths and opportunities and barriers to implementation of selected provisions for reduction of demand and supply according to each country’s priorities.

(b) A significant expansion of work has taken place in Africa. Direct technical assistance and support are being provided to countries in the African Region to build capacity for policy change and programmatic work. The Centre for Tobacco Control in Africa was set up, hosted by Makerere University School of Public Health in Kampala, Uganda. WHO started providing technical and financial resources to the Centre in July 2011 and donor funding is committed until July 2014.

(c) The Secretariat has provided finance ministries of 12 Member States across the WHO regions with technical support, expert advice and training to increase the efficiency and effectiveness of their national tobacco tax systems and administration. A further 31 ministries have collectively received training on tobacco taxation through regional meetings and technical workshops. A technical manual on tobacco tax administration\(^\text{16}\) and a toolkit on the economic costs of tobacco use\(^\text{17}\) have been published.

(d) Support and technical input have been provided to the Secretariat of the WHO Framework Convention on Tobacco Control for developing guidelines and protocols. The WHO and Convention Secretariats follow an agreed work programme in order to ensure complementarity and minimize duplication.

(e) In response to the recommendation of the High-level Taskforce on Innovative Financing for Health Systems to expand the solidarity levy on airline tickets and explore the technical viability of other solidarity levies on tobacco and currency transactions, the Secretariat has issued a discussion paper on the concept of a solidarity tobacco contribution.\(^\text{18}\)

**Promoting healthy diets and physical activity**

(a) Global and regional capacity-building workshops on implementing the Global Strategy on Diet, Physical Activity and Health have been held in all WHO regions.

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\(^\text{17}\) **Economics of tobacco toolkit: assessment of the economic costs of smoking.** Geneva, World Health Organization, 2011.

(b) Several tools have been designed for use by Member States and other stakeholders based on the recommendations contained in that Global Strategy (see resolution WHA57.17), Global recommendations on physical activity for health have been published, and work continues on a guide for their implementation. The Secretariat has been reviewing evidence of effectiveness of physical activity interventions in settings such as primary health care, schools, the community and workplaces, and relating to transport, the environment and sports.

(c) As proposed by the WHO Forum and Technical Meeting on Population-based Strategies for Childhood Obesity (Geneva, 15-17 December 2009), a tool for prioritizing areas for action by Member States is being pilot tested in all WHO regions.

(d) A network was established in the Western Pacific Region in order to contribute to the reduction of salt intake at the population level and to join the existing networks and expert groups established in the Region of the Americas and the European Region, which have continued to share advice on and raise awareness for the importance of salt reduction for public health.

(e) The United Kingdom Food Standards Agency and the Secretariat jointly convened a technical meeting on creating an enabling environment for population-based salt-reduction strategies (London, 1 and 2 July 2010). Discussions covered interventions for consumer education and reformulation of industrially produced foods so as to enable consumers to reduce the total sodium content of their diet through appropriate choices. A subsequent technical meeting, jointly convened by the Government of Canada and WHO (Calgary, 19 and 20 October 2010), covered monitoring sodium intake levels at population level, assessment of dietary sources of sodium, and knowledge, attitudes and behaviours towards sodium and health. Based on the outcomes of these two meetings, the Secretariat is developing a practical tool for Member States to implement population-based salt-reduction strategies.

(f) In May 2010, the Health Assembly in resolution WHA63.14 endorsed a set of recommendations on the marketing of food and non-alcoholic beverages to children, which call for global action to reduce the impact on children of marketing of foods with high concentrations of saturated fats, trans-fatty acids, free sugars or salt. The Secretariat continues discussions with nongovernmental organizations and the private sector, focusing on responsible marketing of foods to children as well as product reformulation and consumer awareness.

(g) A technical meeting on nutrient profiling was jointly organized by the Secretariat and the International Association for the Study of Obesity (London, 4-6 October 2010). The Secretariat has written a manual for the development or adaptation of nutrient profile models, and catalogued existing nutrient profile models. The manual may be used as a tool by countries when considering the development of nutrient profile models and will be updated after field-testing in countries across all six WHO regions.

(h) In order to update recommendations on dietary intake, the scientific evidence is being systematically reviewed. So far, reviews have covered the intake of total fat and sugars; the intake of salt/sodium and potassium; and the use of salt as a vehicle for iodine fortification.

(i) The Nutrition-Friendly Schools Initiative, to promote healthy dietary practices among school-age children, has been established in 17 countries in the European Region. An Action Network has been created and is hosted by the Government of the Netherlands; it held its first meeting in November 2010. Training materials have been prepared and a meeting of nutrition counterparts was held in March 2011 in Geneva. The Eastern Mediterranean Region conducted Nutrition-Friendly Schools Initiative training in Abu Dhabi, Dubai and Sharjah, United Arab Emirates, in November 2010.

Reducing harmful use of alcohol

(a) Following the endorsement by the Health Assembly in resolution WHA63.13 of the global strategy to reduce the harmful use of alcohol and in line with its monitoring and reporting mechanisms, the Global network of WHO national counterparts for implementation of the global strategy to reduce the harmful use of alcohol was established to ensure effective collaboration and consultations with Member States on implementing the global strategy at different levels. At its inaugural meeting (Geneva, 8–11 February 2011), national counterparts from 126 Member States agreed the working mechanisms and structures of the network, and elaborated the plan of implementation of the global strategy.

(b) The Secretariat continues to monitor alcohol consumption, patterns of drinking, health consequences and policy responses in Member States in order to support them in their efforts to reduce the harmful use of alcohol. WHO’s Global status report on alcohol and health, launched in February 2011, presents comprehensive data at the global, regional and country levels.24

(c) Work has continued on developing and disseminating technical tools and training materials for implementation of different policy options at the national level, including identification and management of hazardous and harmful use of alcohol in health-care settings.

(d) Dialogue continues with nongovernmental organizations, professional associations and economic operators on ways in which they can contribute to reduce the harmful use of alcohol. Consultations were held in Geneva on 12 December 2011 with nongovernmental organizations and professional associations to discuss their engagement in the implementation of the global strategy, and on 13 December 2011 with economic operators on ways to reduce alcohol-related harm in their role as developers, producers, distributors, marketers and sellers of alcoholic beverages.

OBJECTIVE 4. To promote research for the prevention and control of noncommunicable diseases

7. The Secretariat published a prioritized research agenda for prevention and control of noncommunicable diseases25 following extensive consultations, production of working papers on major areas for research, and a survey for ranking research priorities. In assigning priorities, special attention was given to research related to policies and interventions that have contributed to declining trends in the prevalence of

noncommunicable diseases in developed countries. Such research aspects included: translation of findings into practice; tracking risk factor trends and monitoring and evaluation; implementation of cost-effective prevention approaches; work that helps to place noncommunicable diseases on the global development agenda; and reducing the cost of effective high-technology interventions for appropriate application in low-resource settings. The research agenda was launched during the first Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control (Moscow, 28 and 29 April 2011), and has been sent to WHO Collaborating Centres, international nongovernmental organizations, donor agencies and leading researchers.

**OBJECTIVE 5. To promote partnerships for the prevention and control of noncommunicable diseases**

8. Actions undertaken by the Secretariat include the following:

(a) The Secretariat organized the First Global Forum of the Noncommunicable Disease Network (Geneva, 24 February 2010). With more than 150 representatives from Member States and civil society, it contributed significantly to raising awareness of and commitment to noncommunicable disease prevention and control, especially in developing countries. Working groups were convened on advocacy and communications, innovative resourcing mechanisms, and monitoring and evaluation.

(b) As a side event to the United Nations High-level Plenary Meeting on the Millennium Development Goals (New York, 20-22 September 2010), the Secretariat convened the second meeting of the International Advisory Council of Noncommunicable Disease Network.

(c) The Secretariat organized several events for stakeholder groups and partners as part of the preparations for the United Nations High-level Meeting on noncommunicable diseases. In November 2010, informal dialogues were held with both the private sector and nongovernmental organizations. In April 2011, the WHO Global Forum on addressing the challenge of noncommunicable diseases was held in Moscow (see paragraph 4(d) above), drawing more than 300 people from a wide variety of stakeholder groups. The proceedings of the Forum were webcast.

(d) WHO has been supporting the work of the Non-Communicable Diseases Civil Society Task Force set up by the President of the United Nations General Assembly to advise on civil society participation in the high-level meeting on noncommunicable diseases (New York, 19 and 20 September 2011). The Task Force includes members from nongovernmental organizations, civil society organizations and the private sector. A notable event was an informal interactive hearing for civil society (New York, 16 June 2011), held at the request of the General Assembly and which was also webcast. The outcome contributed to the preparations for the high-level meeting.

(e) The Secretariat convened the “First Meeting of UN Funds, Programmes and Agencies on the Implementation of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of NCDs” in New York on 8 December 2011. The meeting resulted in a unified vision and road map for a coordinated United Nations system-wide agenda in support of national efforts.

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for noncommunicable disease prevention and control, including actions related to integrating noncommunicable diseases into United Nations Development Assistance Framework processes and developing joint programmes.

**OBJECTIVE 6. To monitor noncommunicable diseases and their determinants and evaluate progress at the national, regional and global levels**

9. Actions undertaken by the Secretariat include the following:

(a) WHO’s Global status report on noncommunicable diseases 2010, launched in April 2011, provides a base line for the future monitoring of trends and assessing countries’ progress in tackling the epidemic. It sets out clear positions and strategic directions on surveillance, prevention and risk factor reduction, and health care.

(b) A second meeting of WHO’s epidemiology reference group, established in accordance with the action plan, was convened in Geneva in August 2010. The work of the group and subsequent internal meetings resulted in consensus on the basic components and core indicators for national surveillance frameworks for noncommunicable diseases which were included in the Global status report. The three major components of a national surveillance framework are: (i) monitoring exposures (risk factors); (ii) monitoring outcomes (morbidity and disease-specific mortality); and (iii) health system responses. The framework and proposed core indicators are annexed to the Secretariat’s report to the 130th session of the Executive Board.

(c) In order to set realistic and evidence-based targets and indicators for use in mid-term and final evaluations, the Secretariat established the WHO Technical Working Group on NCD Targets, composed of international experts in noncommunicable disease surveillance and WHO staff members. They reviewed the current situation and trends of noncommunicable diseases, and critically assessed the feasibility of achieving the proposed targets on the basis of demonstrated country achievements. In July 2011 the Group drafted a set of recommendations on voluntary targets and indicators for monitoring progress in reducing the burden of noncommunicable diseases as a platform for discussion, and Member States were invited to submit their views. Following further technical work and consultation with Member States, a revised version is being prepared, which will be circulated for further consultation among Member States.

(d) An informal dialogue was held with relevant nongovernmental organizations on a global monitoring framework and voluntary global targets for the prevention and control of noncommunicable diseases on 15 December 2011, the outcomes of which were presented to Member States during an informal consultation with Member States and United Nations agencies on the development of a global monitoring framework and targets for noncommunicable diseases (Geneva, 9 January 2012).

**CONCLUSIONS**

10. Major advances have been made in implementing the global strategy and the action plan. The High-level Meeting of the United Nations General Assembly on Prevention and Control of Noncommunicable Diseases in September 2011 and its preceding preparatory work have made a great and unprecedented contribution to the global struggle against

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30 See document EB130/6.
noncommunicable diseases and their negative socioeconomic consequences. The implementation of the Secretariat’s sets of actions for the six objectives of the action plan for the global strategy has resulted in clear strategic positions and guidance to Member States in the three major areas of action: monitoring noncommunicable diseases and their determinants, preventing risk through effective interventions, and improving health care for people with noncommunicable diseases through health system strengthening.

11. Major challenges remain, however, in implementation at the Member State level. Meeting these challenges requires increased recognition of the importance of strengthening national capacities to deal with noncommunicable diseases, particularly in developing countries, and acknowledgement that this may entail increased and sustained funding. As stated in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, Heads of State and Government and representatives have committed to strengthen national policies and health systems by, inter alia, exploring the provision of adequate, predictable and sustained resources must be explored, through domestic, bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanisms.32

ACTION BY THE HEALTH ASSEMBLY

12. The Health Assembly is invited to note this report.

Document A65/9 (Report by the Secretariat):

Implementation of the action plan for the prevention of avoidable blindness and visual impairment

1. This report provides an overview of progress in implementing the action plan for the prevention of avoidable blindness and visual impairment33 since its endorsement by the Health Assembly in resolution WHA62.1 in May 2009, as requested in that resolution.

2. In January 2012, the Executive Board at its 130th session took note of an earlier version of this report34 and adopted decision EB130(1).

3. The action plan aims (1) to increase political and financial commitment to eliminating avoidable blindness; (2) to facilitate the preparation of evidence-based standards and guidelines, and use of the existing ones, for cost-effective interventions; (3) to review international experience and share lessons learnt and best practices in implementing policies, plans and programmes for the prevention of blindness and visual impairment; (4) to strengthen partnerships, collaboration and coordination between stakeholders involved in preventing avoidable blindness; and (5) to collect, analyse and disseminate information systematically on trends and progress made in preventing avoidable blindness globally, regionally and nationally. The plan comprises five objectives, each with sets of proposed actions for Member States, international partners and the Secretariat.

PROGRESS BY OBJECTIVE

34 See documents EB130/8 and EB130/2012/REC/2, summary record of the ninth meeting.
OBJECTIVE 1. Strengthen advocacy to increase Member States’ political, financial and technical commitment in order to eliminate avoidable blindness and visual impairment

4. Actions undertaken by the Secretariat from 2009 to the present include the following:

(a) In 2011, the Secretariat finalized a global survey to assess Member States’ capabilities for advocacy for provision of resources for eye care. Two questionnaires were distributed to 159 Member States. Responses received to one or both questionnaires from 110 Member States (69%) have been analysed in order to help to determine the best ways of securing the support of high-level decision-makers for investing in eye health. A report is being written.

(b) New estimates of the global magnitude of visual impairment and the distribution of the causes were made in 2010 and issued in 2011. These data are important for monitoring trends and advocating allocation of resources to prevention of avoidable blindness. Age-specific distributions of moderate and severe visual impairment and blindness have been estimated for each WHO region. The results indicate that visual impairment remains a major health problem that is unequally distributed between the WHO regions and among Member States. Of all causes, 80% are estimated to be preventable. The Secretariat plans to issue a factsheet on poverty and visual impairment next year.

(c) Communications have been sent to 137 Member States encouraging them to support eye health and to implement the action plan. Workshops and meetings have been held in 83 countries in order to generate political, financial and technical commitment to tackling avoidable blindness and visual impairment. These have been led by the regional offices.

(d) The Secretariat organized the first stakeholders’ conference on the action plan and the necessary steps to achieve its objectives (Geneva, 14 September 2010), which was attended by representatives of 18 Member States, 13 international partners and the Secretariat. Participants reviewed the experiences in implementing the action plan, discussed challenges and opportunities, and agreed on future steps. The need for global coordination of activities and the mobilization of adequate resources was emphasized. The importance of harmonizing advocacy messages by international partners was highlighted, in particular in terms of strengthening health systems and ensuring equity, access and quality of care.

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

5. Secretariat actions include the following:

(a) In September 2011, the Secretariat organized a WHO consultation on public health management of chronic eye diseases in order to review international experience in implementing strategies for the control of glaucoma, diabetic retinopathy, age-related macular degeneration, childhood blindness and refractive errors (Geneva, 19 and 20 September 2011). Participants reviewed best practices for prevention and treatment in different resource settings. (A report is being prepared for publication in WHO’s Technical Report Series and will propose strategies for tackling chronic eye diseases.)

(b) The Secretariat, in partnership with the World Bank, launched the first World report on disability. It provides new estimates of the global prevalence of

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For global and regional estimates, see http://www.who.int/blindness/en/ (accessed 29 February 2012).

disability and reviews the impact of disability, including that due to blindness or visual impairment. The report provides a set of recommendations to improve the lives of people with disability.37

(c) At country level, the Secretariat has worked with 92 national blindness-prevention committees for eye health, in collaboration with international and national partners, on the development of national plans for eye health care. It has also provided, in conjunction with other partners, technical assistance to 92 Member States for eye-care programmes, including training of primary health-care workers and the development and use of tools for data collection, monitoring and evaluation. In three regions, this work has been complemented with regional workshops to assist countries integrate and strengthen eye health care into primary health care.

(d) The Secretariat is collating information from Member States on how they are approaching avoidable blindness. A database is due to be available in 2012.

(e) In collaboration with Lions Clubs International Foundation, continued support has been provided to Member States to reduce avoidable causes of childhood blindness through 25 implementation centres in various countries in all WHO’s regions. Capacity to offer preventive and screening services and to provide diagnostic, treatment and rehabilitation services for children has increased in those 25 countries through the provision of equipment and training of eye health-care professionals. Further strengthening of this work and its extension to additional countries over the next two years are planned.

(f) Technical support to regional programmes for controlling onchocerciasis and to countries where the disease is endemic, especially for monitoring and evaluation, has been provided through regional meetings and visits to eight disease-endemic countries. The Secretariat has also coordinated cross-border control activities between the Democratic Republic of the Congo and Uganda.

(g) In order to redress the lack of skilled human resources to implement national prevention of blindness programmes, the Secretariat has supported workshops for the training of eye-health professionals. It has also been working with leading global organizations of eye-care professionals on the preparation of a report that identifies examples of educational curricula that are available for the training of clinical and public health eye-care professionals. In 2010, a seminar was held in Geneva with the Global Health Workforce Alliance to discuss ways of training and retaining eye-care health workers in underserved communities.

(h) Five regional offices have staff members who provide technical support to Member States and WHO country offices to tackle visual impairment. In some cases there has been regional presence throughout the past two years, whereas in other cases it has been more intermittent, thus affecting the ability of the Secretariat to provide support to some Member States. Coordination on technical matters between staff at headquarters and the regional offices has been improved through monthly teleconferences.

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

6. Actions undertaken by the Secretariat include the following:

(a) A multicentre international research project is under way to collect and analyse data on the prevalence, risk factors and the impact of uncorrected refractive

37 The report is published in print and in a format accessible for the blind and visually impaired. They include accessible PDF, Braille and the Digital Accessible Information System talking book format (DAISY).
errors. The conclusions of the research are being reviewed in March 2012 and a
final report is expected to be issued in April 2012.

(b) The Secretariat has worked with four WHO collaborating centres over the past two
years to draw up research programmes in line with the action plan. A prioritized
research agenda is currently being finalized.

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

7. Secretariat actions include the following:

(a) A Taskforce consisting of members of the Board of Trustees of the International
Agency for the Prevention of Blindness and the Secretariat was formed to evaluate
and review the partnership, structure and governance of the Global Initiative for
the Elimination of Avoidable Blindness (VISION 2020: the Right to Sight), and to
chart a way forward. This work followed a global meeting of VISION 2020 partners
organized by the Secretariat (Geneva, 12 October 2010). The conclusion of the
Taskforce is for VISION 2020 to focus on meeting the objectives of the action plan
over the next two years. A set of indicators for measuring progress is being
created.

(b) The WHO Monitoring Committee for the Elimination of Avoidable Blindness,
established according to resolution WHA56.26 on elimination of avoidable
blindness, met in 2009 and will hold a meeting in 2012 to support the work of
VISION 2020.

(c) In 2010 and 2011, the Secretariat organized annual monitoring meetings of the
WHO Alliance for the Global Elimination of Trachoma by 2020 (see paragraph 8). In
addition, the membership of the Non-Governmental Development Organization
Coordination Group for onchocerciasis control has been increased from 10 to 15
members.

(d) In 2011, the Secretariat initiated regular electronic newsletters to keep partners
updated on its work. As of May 2012, five will have been issued.38

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

8. Actions undertaken by the Secretariat include the following:

(a) Support has been provided to 33 Member States for collecting data at district level
through Rapid Assessment of Avoidable Blindness surveys in order to determine the
prevalence of blindness and visual impairment, their main causes, the output and
quality of eye-care services and barriers to access to these services. The
Secretariat has also provided support to Member States to collect, review and
analyse other data in order to determine the impact of action at country level.

(b) Participants at the meetings of the WHO Alliance for the Global Elimination of
Trachoma by 2020 held in 2010 and 2011 not only monitored progress, reviewing
opportunities and challenges, but also elaborated coordinated approaches to
elimination in countries endemic for trachoma. These meetings were attended by
Member States, international partners and the private sector. The Secretariat has
also provided technical support to 65 Member States for monitoring the
epidemiology of trachoma, and to 19 Member States for designing protocols,
conducting surveys, drafting national plans for eliminating the disease, and
ensuring surveillance once the disease is no longer endemic.

38 http://www.who.int/blindness/publications/newsletter.
(c) The progress report on onchocerciasis control through ivermectin distribution, which was noted by the Health Assembly in May 2011, indicated that in Africa mass treatment with ivermectin is still not reaching 25 million people in need. In the Region of the Americas, Colombia and Ecuador have stopped ivermectin mass treatment and are now in the three-year post-treatment surveillance period before certification of elimination of the disease in the Region.

(d) The Secretariat has collaborated with the vision loss and neglected tropical diseases working groups as part of the Global Burden of Diseases, Injuries and Risk Factors 2010 Study for the estimation of the burden of visual impairment and trachoma.

Obstacles to implementation

9. The action plan clearly defines the activities necessary for overcoming the challenges in preventing avoidable visual impairment and blindness. These include increasing political awareness of the magnitude of the problem and translating this into resources for eye-care activities, effective national planning that integrates eye care into broader health development plans, increasing human resources, strengthening the infrastructure for delivery of effective eye-care programmes, and wider international development support. Integrating eye care into broader health plans is particularly important given the increase in chronic, noncommunicable eye conditions.

10. Numerous partners are advocating the pressing need to address visual impairment and its risk factors as a public health priority and it is increasingly recognized that visual impairment will impede achievement of the Millennium Development Goals. Nevertheless, investment and official development assistance specifically to support low- and middle-income countries in building sustainable national eye-care systems with sufficient capacity to control visual impairment remains inadequate.

11. The Secretariat has emphasized at various global and regional events the need to finance activities specified in the action plan, but resources for the Secretariat, international partners and many low- and middle-income countries remain inadequate for them to fulfil their responsibilities fully. As a result, several actions proposed in the action plan are delayed. Additional funding and ever-higher levels of commitment and coordination between partners are urgently needed if the action plan is to be fully implemented by 2013.

ACTION BY THE HEALTH ASSEMBLY

12. The Health Assembly is invited to note the report.

RESOLUTION 13.1: Prevention and control of noncommunicable diseases

Executive Board Resolution EB130.R6

Strengthening noncommunicable disease policies to promote active ageing

The Executive Board, having considered the reports on prevention and control of noncommunicable diseases and the need for integrated management of prevention and

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39 See document WHA64/2011/REC/3, summary record of the seventh meeting of Committee B, section B.
control of noncommunicable diseases in order to promote active ageing,\textsuperscript{40} RECOMMENDS to the Sixty-fifth World Health Assembly the adoption of the following resolution:

The Sixty-fifth World Health Assembly,

Having considered the report on the Outcomes of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases and the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control and the report on the implementation of the global strategy for the prevention and control of noncommunicable diseases and the action plan;

Recalling the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, the Moscow Declaration adopted at the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control (Moscow, 28 and 29 April 2011), and the resolution WHA64.11 on preparations for the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases, following on the Moscow Conference;

Recalling the Millennium Development Goals (MDGs) Follow-up Meeting (Tokyo, 2 and 3 June 2011), with the participation of more than 110 countries, about 20 United Nations or regional organizations and civil society organizations, at which it was agreed that noncommunicable diseases are emerging global challenges not only for the post-2015 era, but which also threaten the achievement of the internationally agreed development goals including the Millennium Development Goals;

Noting that an estimated 36 million of the 57 million deaths in the world in 2008 were due to noncommunicable diseases, such as cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, which are largely caused by four common risk factors, namely tobacco use, harmful use of alcohol, unhealthy diet and lack of physical activity, and that nearly 80% of those deaths occurred in developing countries;

Noting that as noncommunicable diseases become more prevalent among older persons, there is an urgent need to prevent noncommunicable disease-related disabilities and to plan for long-term care;

Noting with profound concern that ageing is among the major contributory factors to the rising incidence and prevalence of noncommunicable diseases, which are leading causes of preventable morbidity and disability;

Noting further that the ageing population would require access to affordable medicine to enhance healthy ageing;

Noting also the demographic change, with the world’s population aged 60 years or more increasing at more than three times the overall population growth rate and rising to about 1200 million in 2025; that the ageing of populations has public health and economic implications, including rising rates of noncommunicable diseases; and also the importance of lifelong health promotion and disease prevention activities that can prevent or delay, for example, the onset and severity of noncommunicable diseases and promote healthy ageing;

\textsuperscript{40} Documents EB130/6, EB130/7 and EB130/8.
Recalling resolutions WHA52.7 and WHA58.16 on active ageing that urged Member States to take measures that ensure the highest attainable standard of health and well-being for the rapidly growing numbers of older persons in both developed and developing countries;

Recalling further United Nations General Assembly resolution 57/167, which endorsed the Political Declaration and the Madrid International Plan of Action on Ageing, as well as other relevant resolutions on ageing;

Noting that the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases recognizes that mental and neurological disorders, including Alzheimer’s disease, are an important cause of morbidity and contribute to the global burden of noncommunicable diseases, and therefore it is necessary to provide equitable access to effective health programmes and interventions, including for the whole population, from an early age;

Recognizing the importance of gender-based approaches, solidarity and mutual support for social development, of the realization of the human rights of older persons, of promoting quality of life, health equity and the prevention of age discrimination, and of promoting social integration of aged citizens;

Acknowledging the Rio Political Declaration on Social Determinants of Health, which expressed the determination to achieve social and health equity through actions on the social determinants of health and well-being with a comprehensive intersectoral approach;

Noting the WHO Framework Convention on Tobacco Control and related WHO strategies and action plans, underscoring the importance of addressing common risk factors for noncommunicable diseases;

Welcoming WHO’s focus on prevention and control of noncommunicable diseases through public health action, a primary health care approach and comprehensive health systems strengthening,

1. URGES Member States:

   (1) to develop, implement, monitor and evaluate policies, programmes and multisectoral action on noncommunicable disease prevention and health promotion in order to strengthen healthy ageing policies and programmes and promote the highest standard of health and well-being for older persons;

   (2) to strengthen intersectoral policy frameworks and institutional mechanisms, as appropriate, for integrated management of prevention and control of noncommunicable diseases, including health promotion, health-care and social-welfare services, in order to address the needs of older persons;

   (3) to ensure, where appropriate, that national health strategies on noncommunicable diseases contribute to the achievement of the Millennium Development Goals;

   (4) to promote, as appropriate, conditions that enable individuals, carers, families and communities to encourage healthy ageing, including care for, provision of support to and protection of older persons, taking into account physical and psychological aspects of ageing, and to focus on intergenerational approaches;

41 And where applicable, regional economic integration organizations.
(5) to encourage the active participation of older people in society and in their local community;

(6) to strengthen cooperation and partnership among Member States; at all levels of government, among stakeholders, academia, research foundations, the private sector and civil society, in order to implement plans and programmes effectively;

(7) to highlight the importance of a primary health care approach in national health-care planning, in close collaboration with social services, and of enabling integration of health promotion and prevention and control of noncommunicable diseases into ageing policies;

(8) to encourage making available measures and resources to provide health promotion, health care and social protection for healthy and active ageing, paying special attention to access to affordable medicine and the importance of training, education and capacity-building of the health workforce in collaboration with WHO and partners;

(9) to further strengthen monitoring and evaluation systems for generating and analysing data on noncommunicable diseases, disaggregated by age, sex and socioeconomic status, with the aim of developing equitable evidence-based policies and planning for older persons;

2. REQUESTS the Director-General:

(1) to provide support to Member States in promoting and facilitating further implementation of commitments made at relevant United Nations conferences and summits on noncommunicable diseases and ageing;

(2) to provide support to Member States in placing emphasis on health promotion and disease prevention throughout the life-course starting at the earliest stage possible, including multisectoral approaches to healthy ageing, integrated care for older persons and support for providers of formal and informal welfare services;

(3) to support Member States in developing policies and programmes for access to affordable medicine for the ageing;

(4) to provide further support to Member States in raising awareness of healthy and active ageing and on the positive aspects of ageing by means that include ageing-specific policies and the mainstreaming of ageing in their national strategies;

(5) to support the advancement of country-level systems for monitoring noncommunicable diseases, as appropriate, and continue to develop a comprehensive global monitoring system for prevention and control of noncommunicable diseases to track trends and monitor progress in implementation of the Political Declaration;

(6) to raise the priority given to prevention and control of noncommunicable diseases on the agendas of relevant forums and meetings of national and international leaders in advance of a post-2015 global development agenda;

(7) to consider focusing The world health report 2014 on the global status of ageing, recognizing the importance of strengthening information systems through the inclusion of older adults in the collection, analysis and dissemination of data and information on health status and risk factors;
to report to the Sixty-sixth World Health Assembly, through the Executive Board, on progress made in implementing this resolution.

Executive Board Resolution EB130.R7

Prevention and control of noncommunicable diseases: follow-up to the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases

The Executive Board,

Having considered the reports on prevention and control of noncommunicable diseases: outcomes of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases and the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control and on implementation of the global strategy for the prevention and control of noncommunicable diseases and the action plan;

Recalling the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases, the Moscow Declaration adopted at the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control, and resolution WHA64.11 of the World Health Assembly;

Acknowledging the Rio Political Declaration on Social Determinants of Health, adopted by the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 19-21 October 2011), which expressed the determination to achieve social and health equity through action on the social determinants of health and well-being by a comprehensive intersectoral approach;

Reaffirming the leading role of WHO as the primary specialized agency for health and its leadership and coordination role in promoting and monitoring global action against noncommunicable diseases (as described in paragraphs 13 and 46 of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases);

Reaffirming also the central role of WHO recognized in the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases for monitoring and evaluation and guiding multisectoral engagement;

Recognizing in particular the call made in the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases (paragraphs 61 and 62) to develop a comprehensive global monitoring framework, including a set of indicators, capable of application across regional and country settings, and to develop recommendations for a set of voluntary global targets for the prevention and control of noncommunicable diseases, and to complete this work before the end of 2012;

42 Document EB130/6.
43 Document EB130/7.
44 United Nations General Assembly resolution 66/2.
Recalling resolution WHA61.14, which endorsed the 2008-2013 action plan for the global strategy for the prevention and control of noncommunicable diseases, and recognizing the progress made to date under the action plan;

Reiterating the concern that the rapidly growing magnitude of noncommunicable diseases affects people of all ages, gender, race and income levels, and further that poor populations and those living in vulnerable situations, in particular in developing countries, bear a disproportionate burden and that noncommunicable diseases can affect women and men differently;

Noting with concern the growing double burden of communicable and noncommunicable diseases in Africa, and the need for integrated approaches to their prevention and control;

Noting with concern that an estimated 36 million of the 57 million deaths in the world in 2008 were due to noncommunicable diseases such as cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, and that nearly 80% of those deaths occurred in developing countries,

1. URGES Member States:

   (1) 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;

   (2) to draw upon, based on national contexts, the policies, strategies, programmes and interventions, and tools recommended by WHO, in accordance with paragraph 45 of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases, in order to promote, establish or support and strengthen, by 2013, as appropriate, multisectoral national policies and plans for the prevention and control of noncommunicable diseases;

   (3) to strengthen their commitment to implementing noncommunicable disease programmes in accordance with national priorities, including increased efforts on prevention, diagnostics and treatment and to take steps to accelerate health-related donor harmonization and adherence to aid effectiveness principles, bearing in mind the growing concern about the double burden of communicable and noncommunicable disease in many countries and the need for an integrated response;

   (4) to participate fully in the WHO-led process of developing a comprehensive global monitoring framework, including a set of indicators, capable of application across regional and country settings, and of developing recommendations for a set of voluntary global targets for the prevention and control of noncommunicable diseases before the end of 2012, and to consider incorporating elements of this work into national planning exercises at the earliest opportunity in accordance with national priorities;

2. REQUESTS the Director-General:

   (1) to continue in an inclusive and transparent manner, the process under way to develop, in accordance with paragraphs 61 and 62 of the Political Declaration of the

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45 And, where applicable, regional economic integration organizations.
High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases, a comprehensive global monitoring framework, including a set of indicators, capable of application across regional and country settings, and to develop recommendations for a set of voluntary global targets for the prevention and control of noncommunicable diseases, and to complete this work by the end of 2012, building on the outcomes of the consultation with Member States and organizations in the United Nations system (held on 9 January 2012), as follows:

(a) by the end of January the Secretariat will provide Member States with additional information requested at that consultation;

(b) by the end of February 2012, a web-based consultation on a draft framework and indicators and targets will close, following which WHO will revise the draft documents for step (c);

(c) before the Sixty-fifth World Health Assembly, a second Member States consultation on the framework and indicators and targets will be held;

(d) as part of this process, the Secretariat should also hold consultations with all interested stakeholders;

(e) submit a substantive progress report on the development of a framework, including a set of indicators and targets, to the Sixty-fifth World Health Assembly for consideration;

(f) regional consultations will provide further input into the framework/target process as part of their broader discussions on implementation of the Political Declaration;

(g) complete the work on the global monitoring framework, including a set of indicators and targets, based on a Member States consultation held before the end of 2012;

(h) report on the recommendations relating to paragraphs 61 and 62 of the Political Declaration through the Executive Board at its 132nd session to the Sixty-sixth World Health Assembly;

(2) to develop, in a consultative manner, WHO’s input, called for in paragraph 64 of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases, concerning options for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases through effective and transparent partnership, while safeguarding public health from any potential conflict of interest, and submit it to the Secretary-General by the end of 2012;

(3) to submit a progress report and a timeline for WHO’s input on options for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases through effective partnership to the Sixty-fifth World Health Assembly;

(4) to develop, in a consultative manner, a WHO action plan for the prevention and control of noncommunicable diseases for 2013-2020, building on lessons learnt from the 2008-2013 action plan and taking into account the outcomes of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases, the Moscow Declaration on Healthy Lifestyles and Noncommunicable Disease Control, the Rio Declaration on Social Determinants of

46 And, where applicable, regional economic integration organizations.
47 Ditto.
Health, building on and being consistent with existing WHO strategies and tools on tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity;

(5) to build on work from the 2008–2013 action plan, which, inter alia, called for WHO to provide support to countries in enhancing access to essential medicines, to facilitate engagement by governments and, as appropriate, civil society and the private sector with appropriate safeguards against conflict of interest, in accordance with relevant paragraphs of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases, for improved access to medicines;

(6) to submit to the Sixty-sixth World Health Assembly, through the Executive Board, a WHO action plan for the prevention and control of noncommunicable diseases for 2013–2020 for consideration and possible adoption.
IAPO Statement on the Prevention and Control of NCDs

The International Alliance of Patients’ Organizations (IAPO) calls on all Member States and other healthcare stakeholders to act quickly to implement the UN High-Level Meeting Political Declaration on the prevention and control of non-communicable diseases. The ultimate goals must be to promote effective engagement and to improve the quality of life of all persons at risk or affected by non-communicable and other chronic diseases. Patients’ organizations are essential to the collaboration of the United Nations, World Health Organization and governments to reach these goals.

The International Alliance of Patients’ Organizations is comprised of more than 200 patients’ organizations in all regions of the world representing more than 50 non-communicable diseases. We welcome the opportunity the Declaration provides to address a broad range of NCDs and to work toward the redesign of health systems and the refocus of health and related services to implement effective NCD interventions at regional, sub-regional, and national policy and planning levels.

The International Alliance of Patients’ Organizations calls on Member States and all healthcare stakeholders to:

1. Ensure the WHO Global Strategy for the Prevention and Management of NCDs addresses prevention, diagnosis, treatment, care and support of ALL chronic diseases (including, for example, mental, neuromuscular, immunological, and developmental disorders as well as cardiovascular diseases, cancer, lung diseases and diabetes).

2. Ensure effective implementation as measured by strengthened health systems (including service delivery, medical products, vaccines and technologies, health workforce, health systems financing, health information systems, and patient self-management).

3. Ensure that the patient perspective is solicited and patients actively engaged in the design, leadership, implementation, monitoring and evaluation of effective and sustainable interventions to prevent and manage all NCDs.

4. Ensure that patient organizations are engaged as equal partners with other stakeholders in the development, implementation, and monitoring of legislation, health policies, regulatory frameworks, strategies, guidelines, and standards for NCD prevention and management.

5. Develop and implement, in collaboration with patients and community stakeholders, programs to improve health literacy among all populations, including the most disadvantaged.

6. Increase research on the prevalence and incidence of NCDs and their impact on the lives of patients, families and caregivers and the translation of knowledge into meaningful actions to improve the lives of patients and families.

7. Promote early diagnosis and treatment to reduce morbidity and mortality and improve quality of life.

8. Ensure all policies, programs, and strategies are based on the fundamental right to patient-centered healthcare based on unique needs, preferences and values, as well as patient autonomy and independence.
13.2 Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level*

Document A65/10 (Report by the Director-General):

1. The Executive Board at its 130th session in January 2012 considered an earlier version of this report. The Board adopted resolution EB130.R8.49

2. Mental disorders fall into a broad spectrum of conditions that also include neurological and substance use disorders. Common conditions include depression and anxiety, those due to abuse of alcohol and other substances, and also those that are severe and disabling such as schizophrenia and bipolar disorder. Mental health problems in children and adolescents are of concern because of their high prevalence and the accompanying disabilities. Suicide is an extreme but not uncommon outcome for people with untreated mental disorders. In addition to giving priority to these mental health problems, WHO also accords priority to epilepsy and dementia as neurological conditions that share common aspects with mental disorders in terms of provision of services.

3. Untreated mental, neurological and substance use disorders exact a high toll, accounting for 13% of the total global burden of disease. Unipolar depressive disorder is the third leading cause of disease burden, accounting for 4.3% of the global burden of disease. The estimates for low- and middle-income countries are 3.2% and 5.1%, respectively. Current predictions indicate that by 2030 depression will be the leading cause of disease burden globally. When only the disability component is taken into consideration in the calculation of the burden of disease, mental disorders account for 25.3% and 33.5% of all years lived with a disability in low- and middle-income countries, respectively.

4. Exposure to a humanitarian emergency is a potent risk factor for mental health problems. Social structures and existing formal and informal provisions for the care of persons with severe, pre-existing mental disorders are disrupted. Surveys among people affected by conflicts have found prevalence rates of 17% for depression and 15% for post-traumatic stress disorder – figures that are substantially higher than average prevalence rates in general populations. Other factors that increase peoples’ vulnerability or risk of developing mental health problems include poverty, exposure to domestic violence and abuse, and the presence of chronic disease.

5. The gap between the need for treatment for mental disorders and its provision is wide all over the world. For example, between 76% and 85% of people with severe mental disorders receive no treatment for their mental health problem in low- and middle-income countries; the corresponding range for high-income countries is also high: between 35% and 50%.

6. Mental disorders affect, and are affected by, other noncommunicable diseases such as cancer, cardiovascular disease, diabetes and asthma. Mental disorders can be a precursor of noncommunicable diseases, a consequence of those diseases, or the result of interactive effects. For example, there is evidence that depression predisposes people to developing myocardial infarction, and conversely, myocardial infarctions increase the likelihood of depression.

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* See documents EB130/9 and EB130/2012/REC/2, summary record of the second, fourth, eighth and ninth meetings.
49 See document EB130/2012/REC/1 for the financial and administrative implications for the Secretariat of the adoption of the resolution.
7. People with mental disorders have high mortality rates. For example, people with schizophrenia and major depression have an overall increased risk of mortality 1.6 and 1.4 times, respectively, greater than that of the general population because of physical health problems (such as cancer, diabetes and HIV infection, as well as serious consequences such as suicide) associated with mental disorders.

8. The social and economic impact of mental disability is diverse and far-reaching.
   - Homelessness and incarceration in prisons are common occurrences for people with mental health conditions, which exacerbate their marginalization and precariousness. Rates of mental illness among the homeless can be greater than 50% and studies reveal that more than one third of the prison population has mental health conditions.
   - People with mental health conditions often lack educational and income-generation opportunities, limiting their chances of economic development and depriving them of social networks and status within a community. For example, of all disabilities, severe mental illness is associated with the highest rates of unemployment: up to 90%.
   - People with mental health conditions often have their human rights violated. In addition to restrictions on the right to work and to education, 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), rights of citizenship, and the right to vote and to participate effectively and fully in public life.
   - Mental health conditions frequently lead individuals and families into poverty and hinder economic development at the national level. A recent analysis estimated that the cumulative global impact of mental disorders in terms of lost economic output will amount to US$ 16 000 billion over the next 20 years.\(^{50}\)

9. WHO’s *Mental health atlas 2011*\(^{51}\) provides data that demonstrate the scarcity within countries of resources, particularly financial and human resources, to meet mental health needs. It also underlines the inequitable distribution and inefficient uses of such resources. For instance, globally, 67% of financial resources allocated for mental health are still directed towards mental hospitals despite their being associated with poor health outcomes and human rights violations. Directing this funding towards community-based services would allow access to better and more cost-effective care for many more people.

10. Financing for the treatment and prevention of mental disorders remains insufficient in Member States. Globally, annual spending on mental health is less than US$ 2 per person and less than US$ 0.25 in low-income countries. Median annual mental health expenditures per capita range from US$ 0.20 in low-income countries to US$ 44.84 in high-income countries.

11. Human resources for mental health in low- and middle-income countries are insufficient. For instance, almost half the world’s population lives in countries where, on average, there is one psychiatrist to serve 200 000 or more people, and mental health care providers who are trained in the use of psychosocial interventions, such as psychologists, social workers and occupational therapists, are even scarcer.

12. Globally, nurses make up the largest professional group working in the mental health sector, yet a recent analysis for 58 low- and middle-income countries has identified a

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shortfall of 128 000 nurses between the number available now and the number needed to provide care for patients with priority conditions.

13. A much higher proportion of high-income countries than low-income countries report having a policy, plan and legislation on mental health. For example, only 36% of people living in low-income countries are covered by dedicated mental health legislation compared with 92% in high-income countries.

14. Civil society movements for mental health in low- and middle-income countries are not well developed. Organizations of people with mental 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%.

EFFECTIVE STRATEGIES WITHIN HEALTH AND SOCIAL SECTORS

15. WHO recommends the following strategies:

(a) improve the provision of good-quality treatment and care for mental health conditions, by:
   (i) including mental health into broader health policies and strategies such as those related to general health care, noncommunicable diseases, disability, maternal health and HIV/AIDS;
   (ii) expanding evidence-based mental health interventions in general health services and including them in packages of care, on the basis of cost-effectiveness, affordability and feasibility. For example, treatment of epilepsy with first-line antiepileptic medicines is one of the most cost-effective interventions for noncommunicable diseases; treatment for depression with (generically produced) antidepressant medicines and brief psychotherapy in primary care (altogether less than US$ 1) is very cost effective; treating people with psychosis with older antipsychotic medicines plus provision of psychosocial support is a cost-effective and feasible public-health intervention; and taxation of alcoholic beverages and restriction of their availability and marketing are among the identified “best buys” for reducing the harmful use of alcohol;

(b) improve access for people with or at risk of mental disorders to social welfare services and opportunities for education and employment, by:
   (i) actively supporting children and adolescents to receive an education, particularly primary and secondary level;
   (ii) promoting preschool education for vulnerable children, including those whose parents have mental health conditions, and for children in economically and socially disadvantaged groups; not only is this an effective strategy to improve mental health outcomes, it reduces rates of crime and improves employment in adulthood;
   (iii) including people with mental health conditions in employment and income-generating programmes (for example, small business operations), introducing supported employment programmes, and providing social protection grants;
   (iv) creating strong links between mental health services, housing and other social services;

(c) introduce human rights protection for people with mental health conditions, by:
   (i) developing policies and laws that protect and promote human rights and establishing independent monitoring mechanisms so as to improve conditions in health facilities, in line with international human rights standards such as the United Nations Convention on the Rights of Persons with Disabilities;
(ii) supporting the development of a strong civil society and promoting the full inclusion and participation of people with mental disabilities in public affairs, including policy-making;

(d) protect and promote mental health, by:
   (i) introducing interventions that target early childhood years and family life, with attention to parenting skills and addressing violence and abuse within the home environment, and through school-based mental health promotion programmes;
   (ii) introducing interventions at the workplace that include a focus on reducing stress and contributing factors;
   (iii) building stronger support systems for active ageing that also help to prevent loneliness and isolation;
   (iv) implementing suicide prevention programmes that include restricting access to means of self-harm and providing adequate care for, and follow-up, of people at risk of attempting suicide.

ACTIVITIES OF THE SECRETARIAT

16. WHO’s Mental Health Gap Action Programme,\(^{52}\) launched in 2008, uses a multipronged approach to improving the mental health situation in countries. The Secretariat’s most salient activities are summarized below.

Advocacy

17. WHO has established the Mental Health Gap Action Programme Forum, an informal and evolving group, whose members include Member States, United Nations bodies and other intergovernmental organizations, international development agencies, foundations, academic institutions, nongovernmental organizations and WHO collaborating centres. The Forum, which meets annually, raises the priority given to mental health by Member States and other stakeholders with the aim of providing care for all people with mental, neurological and substance use disorders, with specific attention to low- and middle-income countries.

18. WHO’s recent report on mental health and development\(^{53}\) is also useful for advocacy of the inclusion of mental health in national and international development agendas.

Information and surveillance

19. The Secretariat also has a central role in broadening the evidence base on mental health interventions in order to strengthen mental health-care systems in Member States. This function relies on several projects, as exemplified below.

- Through Project Atlas (see also paragraph 9) the Secretariat maps resources available in Member States. Data collected include information on policies, programmes, financing, services, professionals, treatment and medicines, information systems and relevant organizations. These data are needed at the country level for assessment of the domestic situation, and at the regional and global levels in order to compose an aggregate picture of the available resources and overall needs.


• The WHO Assessment Instrument for Mental Health Systems\textsuperscript{54} enables countries to collect essential information on the mental health system of a country or region therein. The instrument has been applied in more than 80 countries to date. The Secretariat reviews and analyses the data, providing a detailed picture of mental health systems in low- and middle-income countries in order to facilitate the improvement of mental health systems and to provide a baseline for monitoring change.

• The Secretariat collects and analyses data on mental health in the context of general health care and development, and issues the findings as part of its country profile series. Each profile describes the national demographic and socioeconomic situation and provides an analysis of the consequences for mental health services in the country, with detail about the relationship between those services and the general health system. The profiles also describe countries’ efforts to improve the mental health situation and document the milestones and achievements in this reform.

\section*{Policy, law and human rights}

20. The Secretariat also provides support to Member States in the development of comprehensive and realistic mental health policies, strategic plans and laws that promote improved quality and availability of mental health care and the rights of persons with mental disorders, in line with international best practice and human rights standards, including the United Nations Convention on the Rights of Persons with Disabilities.

21. Through its project “QualityRights: act unite and empower for better mental health” the Secretariat provides support to Member States for assessing and improving quality and human rights conditions in outpatient and inpatient mental health services. The project builds the capacity of national actors to assess thoroughly the mental health facilities in the country, using an assessment tool designed for the project, and to promote the creation or strengthening of organizations of people with mental disabilities and families. The results of the assessment and improved participation of civil society feed into the drafting of human rights-oriented policies and laws.

\section*{Service development}

22. The Secretariat also works with Member States in developing mental health services, specifically, in deinstitutionalizing their mental health care, integrating mental health into general health care, and developing community-based mental health services.

23. The objective of the Mental Health Gap Action Programme is to expand services in countries for people with mental, neurological and substance use disorders, especially those with lower incomes. It prioritizes the following: depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to use of alcohol and of illicit drugs, and mental disorders in children. An intervention guide, consisting of evidence-based interventions for prevention and management for each of these priority conditions, has been published.\textsuperscript{55} Training, based on the guide, is provided to health-care providers working in non-specialized health-care settings in low- and middle-income countries, with the aim of moving from stand-alone mental health programmes to an integrated approach that promotes mental health at all levels of care. Many high-income countries are also finding the guide useful in their resource-poor settings.

\section*{Mental health and psychosocial support in humanitarian emergencies}

\textsuperscript{54} Document WHO/MSD/MER/05.2.

24. WHO takes a leading role in addressing mental health problems associated with humanitarian emergencies. It has initiated and cooperated in the preparation of both the Inter-Agency Standing Committee’s Guidelines on mental health and psychosocial support in emergencies settings and a standard on mental health in the revised edition of the Sphere Handbook. During the past decade, WHO has provided substantial emergency and post-emergency support to health ministries for improving people’s mental health in Haiti, Indonesia, Iraq, Jordan, Lebanon, Somalia, Sri Lanka and Syrian Arab Republic among other countries and territories.

**ACTION BY THE HEALTH ASSEMBLY**

25. The Health Assembly is invited to adopt the resolution recommended by the Executive Board in resolution EB130.R8.

**RESOLUTION 13.2: Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level**

**Executive Board Resolution EB130.R8**

The Executive Board, having considered the report on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level, recommends to the Sixty-fifth World Health Assembly the adoption of the following resolution:

The Sixty-fifth World Health Assembly,

Having considered the report on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level;

Recalling resolution WHA55.10, which, inter alia, urged Member States to increase investments in mental health, both within countries and in bilateral and multilateral cooperation, as an integral component of the well-being of populations;

Recalling further United Nations General Assembly resolution 65/95, which recognized that mental health problems are of major importance to all societies and are significant contributors to the burden of disease and the loss of quality of life, and have huge economic and social costs, and which also welcomed the WHO report on mental health and development that highlighted the lack of appropriate attention to mental health and made the case for governments and development actors to reach out to people with mental disorders in the design of strategies and programmes that include those people in education, employment, health, social protection and poverty reduction policies;

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58 Document EB130/9.
Noting the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases (New York, 19-20 September, 2011), at which it was recognized that mental and neurological disorders, including Alzheimer’s disease, are an important cause of morbidity and contribute to the global noncommunicable disease burden, necessitating provision of equitable access to effective programmes and health-care interventions;

Recognizing that mental disorders can lead to disabilities, as reflected in the United Nations Convention on the Rights of Persons with Disabilities, which also notes that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others, and that the World report on disability60 charts the steps that are required to improve the participation and inclusion of people with disabilities, including persons with mental disabilities;

Recognizing also that mental disorders fall within a wider spectrum that also includes neurological and substance-use disorders which also cause substantial disability and require a coordinated response from health and social sectors;

Concerned that millions of people worldwide are affected by mental disorders, that in 2004, mental disorders accounted for 13% of the global burden of disease, defined as premature death combined with years lived with disability, and that, when taking into consideration only the disability component of the burden of disease calculation, mental disorders account for 25.3% and 33.5% of all years lived with a disability in low- and middle-income countries, respectively;

Concerned also that exposure to humanitarian emergencies is a potent risk factor for mental health problems and psychological trauma and that social structures and ongoing formal and informal care of persons with severe, pre-existing, mental disorders are disrupted;

Recognizing further that the treatment gap for mental disorders is high all over the world, that between 76% and 85% of people in low- and middle-income countries with severe mental disorders receive no treatment for their mental health conditions, and that the corresponding figures for high-income countries are also high - between 35% and 50%;61

Recognizing in addition that a number of mental disorders can be prevented and that mental health can be promoted in the health sector and in sectors outside health;

Concerned that persons with mental disorders are often stigmatized and underlining the need for health authorities to work with relevant groups to change attitudes to mental disorders;

Noting also that there is increasing evidence on the effectiveness and cost-effectiveness of interventions to promote mental health and prevent mental disorders, particularly in children and adolescents;

Noting further that mental disorders are often associated with noncommunicable diseases and a range of other priority health issues, including HIV/AIDS, maternal and child health, and violence and injuries, and that mental disorders often coexist with other medical and

social factors, such as poverty, substance abuse and the harmful use of alcohol, and, in the case of women and children, greater exposure to domestic violence and abuse;

Recognizing that certain populations live in a situation that makes them particularly vulnerable to developing mental disorders, and the consequences thereof;

Recognizing that the social and economic impact of mental disorders, including mental disabilities, is diverse and far-reaching;

Taking into account the work already carried out by WHO on mental health, particularly through the mental health Gap Action Programme,

1. **URGES Member States:**

   (1) according to national priorities and within their specific contexts, to develop comprehensive policies and strategies that address the promotion of mental health, prevention of mental disorders, and early identification, care, support, treatment and recovery of persons with mental disorders;

   (2) to include in policy and strategy development the need to promote human rights, tackle stigma, empower service users, address poverty and homelessness, tackle major modifiable risks, and as appropriate, promote public awareness, create opportunities for generating income, provide housing and education, provide health-care service and community-based interventions, including deinstitutionalized care;

   (3) to develop, as appropriate, surveillance frameworks that include risk factors as well as social determinants of health to analyse and evaluate trends regarding mental disorders;

   (4) to give appropriate priority to and streamlining of mental health, including the promotion of mental health, the prevention of mental disorders, and care, support and treatment in programmes addressing health and development and to allocate appropriate resources in this regard;

   (5) to collaborate with WHO in the development of a comprehensive mental health action plan;

2. **REQUESTS the Director-General:**

   (1) to strengthen advocacy, and develop a comprehensive mental health action plan with measurable outcomes, based on an assessment of vulnerabilities and risks, in consultation with and for consideration by Member States, covering services, policies, legislation, plans, strategies and programmes to provide treatment, facilitate recovery and prevent mental disorders, promote mental health and empower persons with mental disorders to live a full and productive life in the community;

   (2) to include in the comprehensive mental health action plan, provisions to address:
      (a) assessment of vulnerabilities and risks as a basis for developing the mental health action plan;

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62 And, where applicable, regional economic integration organizations.
(b) protection, promotion and respect for the rights of persons with mental disorders including the need to avoid stigmatization of persons with mental disorders;

(c) equitable access to affordable, quality and comprehensive health services that integrate mental health into all levels of the health-care system;

(d) development of competent, sensitive, adequate human resources to provide mental health services equitably;

(e) the promotion of equitable access to quality health care including psychosocial interventions and medication and addressing physical health-care needs;

(f) enhanced initiatives, including in policy, to promote mental health and prevent mental disorders;

(g) access to educational and social services, including health care, schooling, housing, secure employment and participation in income-generation programmes;

(h) involvement of civil society organizations, persons with mental disorders, families and caregivers in voicing their opinions and contributing to decision-making processes;

(i) the design and provision of mental health and psychosocial support systems that will enable community resilience and will help people to cope during humanitarian emergencies;

(j) participation of people with mental disorders in family and community life and civic affairs;

(k) mechanisms to involve the education, employment and other relevant sectors in Member States in the implementation of the mental health action plan;

(l) to build upon the work already done and avoid duplication of action;

(3) to collaborate with Member States, and as appropriate, with international, regional and national nongovernmental organizations, international development partners and technical agency partners in the development of the mental health action plan;

(4) to work with Member States and technical agencies to promote academic exchange, through which to contribute to policy-making in mental health;

(5) to submit the comprehensive mental health action plan, through the Executive Board at its 132nd session, for consideration by the Sixty-sixth World Health Assembly.
13.3 Nutrition

- Maternal infant and young child nutrition (doc A65/11)
- Nutrition of women in the preconception period, during pregnancy and the breastfeeding period (doc A65/12)

Document A65/11 (Report by the Secretariat):

Maternal, infant and young child nutrition: draft comprehensive implementation plan

1. At the 130th session of the Executive Board in January 2012, the draft implementation plan was discussed. In decision EB130(2), inter alia, the Director-General was requested to conduct, as soon as possible, further consultations regarding the targets within the existing draft comprehensive implementation plan via a web-based process open to all Member States, as well as multilateral organizations, to provide further guidance in the finalization of the comprehensive implementation plan. This consultation was held 6-27 February 2012. The draft plan reflects the outcome of the consultation (see Annex).

2. In May 2010, the Health Assembly in resolution WHA63.23 on infant and young child nutrition requested the Director-General “to develop a comprehensive implementation plan on infant and young child nutrition as a critical component of a global multisectoral nutrition framework”. In January 2011, the Executive Board noted the preparatory work on such a plan, making several suggestions on its content, including revising its name to cover maternal nutrition and paying more attention to the double burden of undernutrition and overweight. In May 2011 the Health Assembly noted the report on the subject and the revised outline of the plan.

3. In the course of 2011, five regional consultations to collect feedback on the outline of the comprehensive implementation plan were convened in the African Region, the Region of the Americas, and the South-East Asian, Eastern Mediterranean and Western Pacific regions. Altogether, the consultations were attended by representatives of different government sectors (health, agriculture, social welfare, education, trade, finance, environment and industry) from 92 Member States, organizations in the United Nations system, development banks, donors and civil society.

4. The annexed draft implementation plan integrates all comments provided by Member States during meetings of WHO’s governing bodies and the regional consultations. It brings together relevant elements from the global strategy for infant and young-child feeding, the Global Strategy on Diet, Physical Activity and Health, and the action plan for the global strategy for the prevention and control of noncommunicable diseases. WHO’s

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63 See document EB130/10 and the summary records of the second and ninth meetings in document EB130/2012/REC/2.
64 Comments were received by ten Member States and six multilateral organizations. The background paper and the summary of the comments received and the responses provided by the Secretariat are available at http://www.who.int/nutrition/events/2012_consultation_proposed_globaltargets/en/index.html (accessed 21 March 2012).
65 See documents EB128/18 and EB128/2011/REC/2, summary record of the tenth meeting.
66 See the summary record of the fourth meeting of Committee B, section 5 of the Sixty-Fourth World Health Assembly.
67 Endorsed in 2002 by the Health Assembly in resolution WHA55.25.
68 Endorsed in 2004 by the Health Assembly in resolution WHA57.17.
69 Endorsed in 2008 by the Health Assembly in resolution WHA61.14.
framework for priority action for HIV and infant feeding, issued in 2003, has been recently updated to reflect the revised WHO guidelines for the prevention of mother-to-child transmission of HIV.\textsuperscript{70}

5. Several related regional strategies and plans have been considered in preparing this draft comprehensive plan: the African Union’s Revised African Regional Nutritional Strategy (2005-2015), the Second European Action Plan for Food and Nutrition Policy (2007-2012),\textsuperscript{71} the Strategy and Plan of Action for the Reduction of Chronic Malnutrition,\textsuperscript{72} the Regional strategy on nutrition 2010-2019,\textsuperscript{73} the regional nutrition strategy for South-East Asia\textsuperscript{74} and the Framework for Action on Food Security in the Pacific.\textsuperscript{75}

6. The draft comprehensive implementation plan sets out its rationale, namely the fact that, worldwide, nutrition challenges are multifaceted, effective nutrition actions exist but are not expanded sufficiently, and that new initiatives have been launched. The plan defines its objectives and sets five global targets and a time frame. It further proposes a series of five high-priority actions for Member States, the Secretariat and international partners, and lists effective health interventions and non-health activities that affect nutrition as well as indicators for monitoring the implementation of the plan.

**New initiatives in nutrition**

7. The optimal strategy to ensure rapid improvement of nutrition requires the implementation of a set of specific nutrition interventions and the integration of nutrition into health, agriculture, education, employment, social welfare and development programmes. The Scaling Up Nutrition movement, launched in 2010, has brought together government authorities from countries with high burden of malnutrition and a global coalition of partners. It calls for intensive efforts to scale up nutrition over the period 2013-2015 through such a strategy. Partners in the movement have committed themselves to work together to mobilize resources, provide technical support, perform high-level advocacy and develop innovative partnerships.

8. In order to respond to the challenges to successful coordination, organizations in the United Nations system have committed themselves to better align their activities at global level through the reform of the United Nations Standing Committee on Nutrition and at country level through the Renewed Efforts against Child Hunger and Undernutrition (REACH) initiative.

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\textsuperscript{71} Adopted in 2007 by the Regional Committee for Europe in resolution EUR/RC57/R4.

\textsuperscript{72} Endorsed in 2010 by PAHO’s Directing Council in resolution CD50.R11.

\textsuperscript{73} Endorsed in 2010 by the Regional Committee for the Eastern Mediterranean in resolution EM/RC57/R.4.

\textsuperscript{74} Endorsement by Member States of this strategy was urged in 2011 by the Regional Committee for South-East Asia in resolution SEA/RC64/R4.

9. The initiative for the elimination of new HIV infections in children and improving the health and survival of HIV-infected mothers\(^{76}\) supports the improvement of the nutritional state of mothers and their children.

10. At regional level, a successful example of partnership is the Pan American Alliance for Nutrition and Development for the Achievement of the Millennium Development Goals, launched in 2009.

11. The draft comprehensive implementation plan contributes to the global initiatives by identifying global targets and priority actions in the health sector and defining roles for concerned parties. Specific discussions have been organized with this purpose.

**IMPLEMENTATION OF THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES**

12. In response to the requirement for biennial reporting,\(^{77}\) this report also provides information on progress made by countries in the implementation of the International Code of Marketing of Breast-milk Substitutes. The comprehensive implementation plan also covers this area and proposes future activities.

13. The implementation of the International Code of Marketing of Breast-milk Substitutes, adopted by the Health Assembly in resolution WHA34.22, and of subsequent related Health Assembly resolutions is not consistent among countries. Statutory regulations have been put in place in 103 Member States and have been drafted in nine. Some 37 Member States rely on voluntary compliance by infant formula manufacturers and 25 Member States have not taken action to enforce the Code; information is missing for 20 Member States.\(^{78}\)

14. Among the Member States with legislation, most have provisions on the prohibition of promotion of designated products to the general public and health workers and in health-care facilities, as well as provisions on labelling requirements. Fewer Member States have provisions on contamination warnings, and bans on nutrition and health claims.

15. Less than 50% of countries with legal measures also have legal provisions on monitoring implementation of the Code. Only 37 countries have established functioning monitoring and/or enforcement mechanisms, and limited information on the composition, mandate and functions of such mechanisms is available.

16. Information on implementation of the Code is also provided by regional offices, in collaboration with partners in government and the United Nations system. A recent PAHO review on implementation of the Code in the period 1981-2011 indicates that 16 countries have legal measures and six of them regulate the implementation of the law.\(^{79}\) In 2007 a

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\(^{77}\) Article 11.7 of the International Code; information is collected periodically from Member States by questionnaire, the latest surveys of the status of implementation being issued in 2008 and 2010.

\(^{78}\) Information from UNICEF; these countries also include all Member States that reported on Code implementation, as required under Code Articles 11.6 and 11.7. Questionnaires were sent to Member States in 2007 and 2009 and the results were summarized in documents A61/17 Add.1, section F, and A63/9.

review by UNICEF of 24 West and Central African countries reported that half those countries had comprehensive legal measures in place.\textsuperscript{80}

17. An analysis by the Secretariat of nutrition policies in Member States in 2010\textsuperscript{81} highlighted the following challenges: legislation can only be applied in public health facilities, does not provide clear operational guidance, is poorly enforced and inadequately monitored; health workers are not adequately trained; and the public is not adequately informed.

**ACTION BY THE HEALTH ASSEMBLY**

18. The Health Assembly is invited to endorse the comprehensive implementation plan on maternal, infant and young child nutrition.

**ANNEX**

**DRAFT COMPREHENSIVE IMPLEMENTATION PLAN ON MATERNAL, INFANT AND YOUNG CHILD NUTRITION**

**RATIONALE**

Global nutrition challenges are multifaceted

1. Adequate provision of nutrients, beginning in early stages of life, is crucial to ensure good physical and mental development and long-term health. Poor availability or access to food of adequate nutritional quality or the exposure to conditions that impair absorption and use of nutrients has led to large sections of the world’s population being undernourished, having poor vitamin and mineral status or being overweight and obese, with large differences among population groups. These conditions are often present simultaneously and are interconnected.

2. In women, both low body mass index and short stature are highly prevalent in low-income countries, leading to poor fetal development, increased risk of complications in pregnancy, and the need for assisted delivery.\textsuperscript{82} In some countries in south-central Asia, more than 10% of women aged 15-49 years are shorter than 145 cm. In sub-Saharan Africa, south-central and south-eastern Asia, more than 20% of women have a body mass index less than 18.5 kg/m\textsuperscript{2} and this figure is as high as 40% in Bangladesh, Eritrea and India. Conversely, an increased proportion of women start pregnancy with a body mass index greater than 30 kg/m\textsuperscript{2}, leading to increased risk of complications in pregnancy and delivery as well as heavier birth weight and increased risk of obesity in children.


\textsuperscript{81} See http://www.who.int/nutrition/EB128_18_Backgroundpaper1_A_review_of_nutritionpolicies.pdf (accessed 27 March 2012).

3. Iron-deficiency anaemia affects 30% of women of reproductive age (468 million), and 42% of pregnant women (56 million). Maternal anaemia is associated with reduced birth weight and increased risk of maternal mortality. Anaemia rates have not improved appreciably over the past two decades.\(^{83}\)

4. Every year an estimated 13 million children are born with intrauterine growth restriction\(^{84}\) and about 20 million with low birth weight.\(^{85}\) A child born with low birth weight has a greater risk of morbidity and mortality and is also more likely to develop noncommunicable diseases, such as diabetes and hypertension, later in life.

5. In 2010 about 115 million children worldwide were underweight, 55 million had low weight for their height and 171 million under the age of five years had stunted growth.\(^{86}\) The proportion of children under the age of five years in developing countries who were underweight is estimated to have declined from 29% to 18% between 1990 and 2010, a rate that is still inadequate to meet the Millennium Development Goal 1, Target 1.C of halving levels of underweight between 1990 and 2015. Sufficient decline took place in Asia and Latin America, but considerable efforts are still needed in Africa. In addition, in 2010, 43 million preschool children in developing and developed countries were overweight or obese.\(^{87}\) The prevalence of childhood obesity in low- and middle-income countries has been accelerating in the past 10 years; WHO estimates that in 2015 the rate will reach 11%, close to the prevalence in upper-middle-income countries (12%). Obese children are likely to grow into obese adults; have an increased risk of type 2 diabetes, liver disease and sleep-associated breathing disorders; and have diminished chances of social and economic performance in adult life.

6. Anaemia affects 47.4% (293 million children) of the preschool-age population,\(^{88}\) and 33.3% (190 million) of the preschool-age population globally is deficient in vitamin A.\(^{89}\)

7. Nutritional status is also influenced by several environmental factors. In countries where the prevalence of HIV infection is high, HIV infection has both a direct impact on the nutritional status of women and children who are infected and an indirect effect through alterations in household food security and inappropriate choices of infant-feeding practices in order to prevent mother-to-child transmission of HIV. Poor food security also increases risk-taking behaviour by women that places them at increased risk of becoming infected with HIV. Tobacco use (both smoking and smokeless tobacco) during pregnancy adversely affects fetal health. Direct maternal smoking as well as exposure to second-hand smoke during pregnancy increases the risk of complications in pregnancy, including low birth weight and preterm birth. More people are smoking in many low- to middle-income countries, in particular young girls and women of reproductive age. Although the proportion of women smoking is low in many countries, women and their offspring still face substantial risks of adverse pregnancy outcomes because of their exposure to second-hand smoke. Use of tobacco transmits tobacco contaminants to the fetus through the...
placenta and to neonates through breast milk. Expenditure on tobacco also limits the capacity of families to provide better nutrition for pregnant women and children.

8. Childhood malnutrition is the underlying cause of death in an estimated 35% of all deaths among children under the age of five years. More than two million children die each year as a result of undernutrition before the age of five years and iron-deficiency anaemia is estimated to contribute to a significant number of maternal deaths every year in low- and middle-income countries. Maternal and child undernutrition account for 11% of the global burden of disease.

9. Malnutrition has a negative impact on cognitive development, school performance and productivity. Stunting and iodine and iron deficiencies, combined with inadequate cognitive stimulation, are leading risk factors contributing to the failure of an estimated 200 million children to attain their full development potential. Each 1% increase in adult height is associated with a 4% increase in agricultural wages and eliminating anaemia would lead to an increase of 5% to 17% in adult productivity. Malnutrition is an impediment to the progress towards achieving Millennium Development Goals 1 (Eradicate extreme poverty and hunger), 2 (Achieve universal primary education), 3 (Promote gender equality and empower women), 4 (Reduce child mortality), 5 (Improve maternal health) and 6 (Combat HIV/AIDS, malaria and other diseases).

Effective nutrition actions exist but are not implemented on a sufficiently large scale

10. A review and policy analysis of Member States in 2009–2010 indicated that most countries have a range of policies and programmes on nutrition. However, such policies are often inadequate in the face of the complexity of the challenges of maternal, infant and young child nutrition and do not produce the expected impact.

11. Even when nutrition policies exist, they have not always been officially adopted, often do not articulate operational plans and programmes of work with clear goals and targets, timelines and deliverables; they do not specify roles and responsibilities for those involved, or identify workforce and capacity needs; and they do not include process and outcome evaluation.

12. The policy review indicated that correcting maternal undernutrition was not a priority in countries with a high burden of maternal mortality. Few of the 36 countries with the greatest burden of undernutrition implement on a national scale the full set of effective interventions to prevent child underweight and maternal undernutrition and to foster early child development.

13. Interventions that can be managed directly by the health sector lack detailed implementation guidance and are only partially implemented where health systems are weak. Many countries have adopted integrated strategies for maternal, newborn and child health that incorporate nutrition interventions, but the actual delivery of nutrition support in health services is often inadequate and few indicators are available to measure the coverage.

14. National development strategies do not give due consideration to nutrition. National food and nutrition policies often focus on information and informed-choice models and give little attention to structural, fiscal and regulatory actions aimed at changing unfavourable food environments.

15. Programme implementation is not well coordinated among different actors. In all regions most coordination and administration of policies occurred within health ministries, with variable input from ministries of education, agriculture, food and welfare. Policy and programme implementation often depends on external funding and is not sustainable. Monitoring of activities is either not regularly done or is poorly done.

16. The implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent related Health Assembly resolutions is not consistent among countries. Statutory regulations have been put in place in 103 Member States and have been drafted in 9; 37 Member States rely on voluntary compliance by infant formula manufacturers, and 25 Member States have not taken action to enforce the Code; information is missing for 20 Member States.93

17. In most of those 103 Member States, the legislation makes provisions for the prohibition of promotion of designated products to the general public and health workers and in health-care facilities, and sets labelling requirements. Fewer Member States have provisions on contamination warnings, and bans on nutrition and health claims.

18. Less than 50% of countries with legal measures also have legal provisions on monitoring implementation of the Code. Only 37 of those countries have established functioning monitoring and/or enforcement mechanisms, and limited information on the composition, mandate and functions of such mechanisms is available.

19. Regional offices continue to update the information on implementation of the Code. A recent PAHO review on implementation over the period 1981–201194 indicated that 16 countries have legal measures and six of them regulate the implementation of the relevant law. In a review in 2007, UNICEF found that, of 24 West and Central African countries,95 half had comprehensive legal measures in place.

OBJECTIVE, TARGETS AND TIME FRAME

20. The plan aims to alleviate the double burden of malnutrition in children, starting from the earliest stages of development. Substantial benefits can be obtained by concentrating efforts from conception through the first two years of life, but at the same time a life-course approach needs to be considered so that good nutritional status can be maintained.

21. Progress can be made in the short term, and most nutrition challenges can be resolved within the current generation. For example, currently available nutrition interventions should be able to avert at least one third of the cases of stunting in the

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93 Information from UNICEF; these countries also include all Member States that reported on implementation of the Code, as required by its Articles 11.6 and 11.7. Questionnaires were sent to Member States in 2007 and 2009 and the results were summarized in documents A61/17 Add.1, section F, and A63/9.


short term.\textsuperscript{96} However, full elimination of some conditions may require a longer time frame and commitment for a decade of investment to expand nutrition interventions should be made, with the aim of averting one million child deaths per year. Taking into account the need to align the implementation of the plan to other development frameworks that also consider nutrition, it is proposed that this plan has a 13-year time frame (2012-2025). Reporting will be done biennially until 2022 and the last report will be done in 2025.

22. Global targets are important to identify priority areas and to catalyse global change. Global targets may inspire choices of priorities and ambitions established at country level. They are not meant to dictate the choices of individual countries and regions. Global targets may be used to measure achievements and to develop accountability frameworks. Targets are needed for nutrition conditions that are responsible for a large burden of nutrition-related morbidity and mortality from conception through the first two years of life: stunting, maternal anaemia and low birth weight.\textsuperscript{97} Child underweight - of which stunting represents the largest fraction - is the largest cause of deaths and disability-adjusted life years in children under the age of five years, and iron deficiency contributes to maternal mortality in low- and middle-income countries. Such targets would complement and underpin Target 1.C of Millennium Development Goal 1 in relation to reducing the prevalence of underweight children. Under that Goal, a fourth target on childhood overweight is warranted, given the rapid increase observed globally in the prevalence of that condition. The proposed targets are based on country experiences and the existence of effective interventions.

23. **Global target 1: 40% reduction of the global number of children under five who are stunted by 2025.** This target implies a relative reduction of 40% of the number of children stunted by the year 2025, compared to the baseline of 2010. This would translate into a 3.9% relative reduction per year between 2012 and 2025\textsuperscript{98} and implies reducing the number of stunted children from the 171 million in 2010 to approximately 100 million, i.e. approximately 25 million less than what this number would be if current trends are not changed.\textsuperscript{99} An analysis of 110 countries for which stunting prevalence is available on at least two occasions in the 1995-2010 period\textsuperscript{100} reveals that global stunting is dropping at the rate of 1.8% per year (2.6% in countries with prevalence higher than 30%). In this period 20% of the countries have reduced stunting at a rate of 3.9% or higher.

24. **Global target 2: 50% reduction of anaemia in women of reproductive age by 2025.** This target implies a relative reduction of 50% of the number of non-pregnant women of reproductive age (15-49 years) affected by anaemia by the year 2025, compared to a baseline set in the period 1993-2005 and used as a reference starting point. This would translate into a 5.3% relative reduction per year between 2012 and 2025 and implies reducing the number of anaemic non-pregnant women to approximately 230 million. Several countries have demonstrated a reduction in anaemia prevalence in non-pregnant women, as indicated by repeated national surveys reported in the Sixth report on the world nutrition situation of the United Nations Standing Committee on Nutrition.\textsuperscript{101} China


\textsuperscript{97} The development of global targets has been requested by Member States during regional consultation. Draft targets have been discussed at the regional consultations in the Region of the Americas and the Eastern Mediterranean Region but broader discussion with Member States is required at the Executive Board and through electronic consultation.

\textsuperscript{98} $r = \ln(P1/P2)/t$.


\textsuperscript{100} Obtained from 430 data points.

from 50% to 19.9% in 21 years (1981-2002); Nepal from 65% to 34% in 8 years (1998-2006); Sri Lanka from 59.8% to 31.9% in 13 years (1988-2001); Cambodia from 56.2% to 44.4% in 6 years (2000-2006); Viet Nam from 40% to 24.3% in 14 years (1987-2001); and Guatemala from 35% to 20.2% in 7 years (1995-2002). These estimates point to a 4% to 8% relative reduction per year.

25. **Global target 3: 30% reduction of low birth weight by 2025.** The target implies a relative reduction of 30% of the number of infants born with a weight lower than 2500 grams by the year 2025, compared to a baseline set in 2006-2010 and used as a reference starting point. This would translate into a 3.9% relative reduction per year between 2012 and 2025. In Bangladesh and India, where around half the world’s children with low birth weight are born, the prevalence of low birth weight decreased, respectively from 30.0% to 21.6% (between 1998 and 2006) and from 30.4% to 28.0% (between 1999 and 2005). Reduction in the prevalence of low birth weight has been observed in El Salvador (from 13% to 7% between 1998 and 2003), South Africa (15.1% to 9.9% from 1998 to 2003), and the United Republic of Tanzania (from 13.0% to 9.5% between 1999 and 2005). In these examples, the recorded reductions are in the order of 1% to 12% per year. The higher reduction rates have been observed in countries where a large proportion of the low birth weight is accounted for by intrauterine growth restriction, which is more amenable to reduction than pre-term birth.

26. **Global target 4: No increase in childhood overweight by 2025.** The target implies that the global prevalence of 6.7% (95% confidence interval (CI) 5.6-7.7) estimated for 2010 should not rise to 10.8% (in 2025) as per current trends and that the number of overweight children under five years should not increase from 43 million to approximately 70 million as it could be forecast. The rates of increase are variable in different parts of the world, with more rapid increases in countries that are rapidly expanding their food systems, such as in North Africa. In higher income countries national and regional level information indicates that higher socioeconomic groups have a lower increase in childhood obesity. Lifestyle and environmental interventions used in such circumstances can be used as an example of good practice. In low- and middle-income countries little programmatic experience exists. Programmes aimed at curbing childhood obesity have mainly targeted school age children. It would also be important to prevent an increase in childhood overweight in countries that are addressing the reduction of stunting.

27. **Global target 5: Increase exclusive breastfeeding rates in the first six months up to at least 50% by 2025.** This target implies that the current global average, estimated to be 33.7% for the period 2006-2010, should increase to 50% by 2025. This would involve a 2.3% relative increase per year and would lead to approximately 10 million more children being exclusively breastfed until six months of age. Globally, exclusive breastfeeding rates increased from 14% in 1985 to 38% in 1995, but decreased subsequently in most regions. However, rapid and substantial increases in exclusive breastfeeding rates, often exceeding the proposed global target, have been achieved in individual countries in all regions, such as Cambodia (from 12% to 60% between 2000 and 2005), Mali (from 8% to 38% between 1996 and 2006) and Peru (from 33% to 64% between 1992 and 2007).

28. **Global target 6: Reducing and maintaining childhood wasting to less than 5%.** This target implies that the global prevalence of childhood wasting of 8.6% estimated for 2010 should be reduced to less than 5% by 2025 and maintained below such levels. In the

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104 WHO global and regional trend estimates for child malnutrition, see http://www.who.int/nutgrowthdb/estimates/en/index.html (accessed 23 April 2012).
period 2005-2010, 53 countries reported childhood wasting rates above 5% at least once. Wasting reduction requires the implementation of preventive interventions such as improved access to high-quality foods and to health care; improved nutrition and health knowledge and practices; promotion of exclusive breastfeeding for the first six months and promotion of improved complementary feeding practices for all children aged 6-24 months; and improved water and sanitation systems and hygiene practices to protect children against communicable diseases. Large numbers of children with severe wasting can be treated in their communities without being admitted to a health facility or a therapeutic feeding centre.\(^{105}\) For moderate acute malnutrition, treatment should be based on optimal use of locally available food, complemented when necessary by specially formulated supplementary foods.

**ACTIONS**

29. This action plan illustrates a series of priority actions that should be jointly implemented by Member States and international partners. Specific regional and country adaptation will be needed, led by the relevant national and regional institutions.

**ACTION 1: To create a supportive environment for the implementation of comprehensive food and nutrition policies**

30. Progress towards nutrition goals requires high-level policy commitment and broad societal support. Existing food and nutrition policies need to be reviewed so that they comprehensively meet all main nutrition challenges and deal with the distribution of those problems within society. A further aim of such review is to ensure that nutrition is placed centrally in other sectoral policies and in overall development policy. Crucial factors for the successful implementation of these policies are: (a) official adoption by relevant governmental bodies; (b) the establishment of an intersectoral governance mechanism; (c) the engagement of development partners; and (d) the involvement of local communities. The private sector may also contribute to a better food supply and to increased employment and therefore income. Adequate safeguards to prevent potential conflicts of interest should be put in place.

31. **Proposed activities for Member States**

(a) revise nutrition policies so that they comprehensively address the double burden of malnutrition with a human rights-based approach and an official endorsement of parliament or government;

(b) include nutrition in the country’s overall development policy, Poverty Reduction Strategy Papers and relevant sectoral strategies;

(c) establish effective intersectoral governance mechanisms for implementation of nutrition policies at national and local levels that contribute towards policy integration across sectors;

(d) engage local governments and communities in the design of plans to expand nutrition actions and ensure their integration in existing community programmes;

(e) establish a dialogue with relevant national and international parties and form alliances and partnerships to expand nutrition actions with the establishment of adequate mechanisms to safeguard against potential conflicts of interest.

32. **Proposed activities for the Secretariat**

(a) provide support to Member States, on request, in strengthening national nutrition policies and strategies, and nutrition components of other sectoral policies including national development policies and Poverty Reduction Strategy Papers;
(b) improve access to normative and policy guidelines, knowledge products, tools and expert networks.

33. **Proposed activities for international partners**

(a) implement global advocacy initiatives that increase public awareness of the need to expand actions on nutrition;
(b) strengthen international cooperation on nutrition in order to harmonize standards, policies and actions through adequate mechanisms and intergovernmental bodies, such as the World Health Assembly, the Committee on World Food Security and the United Nations Economic and Social Council;
(c) engage in international coordination mechanisms or partnerships, including the Scaling Up Nutrition movement and the United Nations System Standing Committee on Nutrition.

**ACTION 2: To include all required effective health interventions with an impact on nutrition in national nutrition plans**

34. Many diverse interventions aimed at changing behaviours, providing nutritional support and reducing the exposure to several environmental risk factors have been shown to be effective and should be considered for implementation at national scale. Tables 1a and 1b list effective direct nutrition interventions and health interventions that have an impact on nutrition and that can be delivered by the health system. The lists include interventions that need to be considered either for selected population groups or in special circumstances, including emergencies. Analysis of the evidence is summarized in a background paper to this plan and reported in the WHO e-Library of Evidence for Nutrition Actions. WHO’s guideline process ensures that evidence is continuously updated and that gaps in research are identified. Such interventions are intended as options that could be implemented on the basis of country needs.

35. The greatest benefits result from improving nutrition in the early stages of life. However, a life-course approach to improving nutrition is also needed, with activities targeting older children and adolescents besides infants and young children, in order to ensure the best possible environment for mothers before conception so as to reduce the incidence of low birth weight and to break the intergenerational cycle of malnutrition. Management of childhood overweight would also require action throughout the school years.

36. Interventions should be integrated into existing health-care systems to the extent possible. They should be linked to existing programmes and delivered as packages, in order to improve cost efficiency. Implementation of WHO’s approaches and interventions - Integrated Management of Childhood Illness, Integrated Management of Adolescent and Adult Illness and Integrated Management of Pregnancy and Childbirth - will be essential.

Furthermore, strengthening health systems forms a central element of a successful nutrition strategy.

37. The design of packages of intervention can be based on country needs and the level of investment. Community-based programmes that integrate different direct nutrition interventions in primary care, with systems to ensure universal access, should be prioritized as being cost-effective. A group of organizations in the United Nations system has jointly produced the United Nations OneHealth Costing Tool - software that can easily be adapted to different country contexts.\(^{109}\)

38. **Proposed activities for Member States**

   (a) include all proven nutrition interventions relevant for the country in maternal, child and adolescent health services and ensure universal access;

   (b) reflect the Global Strategy on Infant and Young Child Nutrition, the Global Strategy on Diet and Physical Activity and the WHO nutrition guidelines in national policies;

   (c) strengthen health systems, promote universal coverage and principles of primary health care;

   (d) develop or where necessary strengthen legislative, regulatory and/or other effective measures to control the marketing of breast-milk substitutes in order to ensure implementation of the International Code of Marketing of Breast-milk Substitutes and relevant resolutions adopted by the Health Assembly;

   (e) engage in vigorous campaigns to promote breastfeeding at the local level.

39. **Proposed activities for the Secretariat**

   (a) review, update and expand WHO’s guidance on and tools for effective nutrition actions, highlight good practice of delivery mechanisms and disseminate the information;

   (b) apply cost-effectiveness analysis to health interventions with an impact on nutrition;

   (c) provide support to Member States, on request, in implementing policies and programmes aimed at improving nutritional outcomes;

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

   (e) convene a meeting with academic partners to develop a prioritized research agenda.

40. **Proposed activities for international partners**

   (a) align plans for development assistance to nutrition actions recognized as effective;

   (b) support the nutrition components of health strategies for maternal and child health, such as the Integrated Maternal Newborn and Child Health Strategy.

41. Sectoral development strategies that are sensitive to issues of nutrition are needed in order to reduce the double burden of undernutrition and overweight; these should aim to promote the demand for and supply of healthier food and to eliminate constraints to its access and to use of healthier food. Many sectors should be engaged, but mainly agriculture, food processing, trade, social protection, education, labour and public information. Cross-cutting issues such as gender equality, quality of governance and institutions, and peace and security should also be considered. These matters could be considered in the development and implementation of a framework akin to the WHO Framework Convention on Tobacco Control, which has provided substantial impetus to the control of tobacco use.

42. The Committee on World Food Security is preparing a global strategic framework on food security and nutrition. In the meantime, a series of general principles can be derived from existing policy frameworks, country experience and analysis of the evidence. For example, chronic malnutrition has been successfully reduced in some countries in South-East Asia and Latin America thanks to the simultaneous implementation of policies and programmes aimed at improving food security, reducing poverty and social inequalities, and enhancing maternal education.

43. For food security, increased access to foods of good nutritional quality\(^\text{110}\) should be ensured in all local markets at an affordable price all year round, particularly through support to smallholder agriculture and women’s involvement but with consideration being given to the potential negative impact of labour-displacing mechanization and cash-crop production and of pressure on women’s time. In food manufacture, the nutrient profile, including better micronutrient content and reduced content of salt, sugar and saturated and trans-fats, needs to be improved. In the area of education, better women’s education and improvements in water and sanitation are associated with better child nutrition.

44. Employment policies are crucial to household food security, but labour policies should also ensure adequate maternity protection and that employees could work in a better environment, including protection from second-hand smoke, and access to healthy food. An adequate environment should be created in the workplace for breastfeeding mothers. Social protection is needed to redress inequalities and must reach the most vulnerable. Cash transfers to the poor are used to guarantee food needs. Conditional cash transfers, linking the receipt of cash to bringing children to health centres and school, can have a positive impact on children’s nutritional status, including increase in height and birth weight.

45. Trade measures, taxes and subsidies are an important means of guaranteeing access and enabling healthy dietary choices. They can be powerful tools when associated with adequate information for consumers through nutrition labelling and responsible food marketing, and with social marketing and promotion of healthy diets and healthy lifestyles.

46. Table 2 provides examples of policy measures that engage different relevant sectors which may be considered.

47. **Proposed activities for Member States**

(a) review sectoral policies in agriculture, social protection, education, labour and trade to determine their impact on nutrition and include nutrition indicators in their evaluation frameworks;

\(^{110}\) Food with high nutrient density and low concentrations of nutrients associated with increased risk of noncommunicable diseases.
(b) establish a dialogue between health and other government sectors in order to consider policy measures that could improve the nutritional status of the population and to address potential conflict between current sectoral policies and health policies aimed at improving nutrition;

(c) implement the recommendations on the marketing of foods and non-alcoholic beverages to children (resolution WHA63.14).

48. Proposed activities for the Secretariat

(a) develop methodological guidelines on the analysis of the health and nutrition impact of sectoral policies, including that on different socioeconomic and other vulnerable groups (e.g. indigenous peoples);

(b) identify and disseminate examples of good practice of sectoral policy measures benefiting nutrition.

49. Proposed activities for international partners

(a) engage in consultations in order to analyse the health and nutrition implications of existing policies involving trade, agriculture, labour, education, and social protection, with the aim of identifying and describing policy options to improve nutritional outcomes;

(b) analyse evidence of effectiveness of interventions aimed at improving food security, social welfare and education in low-income countries.

ACTION 4: To provide sufficient human and financial resources for the implementation of nutrition interventions

50. Technical and managerial capabilities are needed for implementation of nutrition programmes at full scale and for the design and implementation of multisectoral policies. Capacity development should be an integral part of plans to extend nutrition interventions. The availability of human resources limits the expansion of nutrition actions, and the proportion of primary care workers to the population is a major determinant of programme effectiveness. Capacity building in nutrition is required in both the health sector at all levels and other sectors.

51. More financial resources are needed to increase the coverage of nutrition interventions. Currently, nutrition programmes receive less than 1% of overall development assistance. The World Bank has calculated that US$ 10 500 million would be needed each year to implement on a national scale top-priority nutrition interventions in the countries with the highest burden of maternal and child undernutrition.\(^{111}\)

Furthermore, predictable resources are essential to sustain an increased level of programme delivery.

52. Joint efforts are required of both governments and donors. Increased resources may come from innovative financing mechanisms, such as the ones discussed in the context of maternal and child health.

53. Governments need to establish a budget line for nutrition programmes and identify financing targets for nutrition programmes. Excise taxes (for example, on tobacco and alcohol) may be used to establish national funds to expand nutrition interventions.

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54. At the international level, mechanisms considered for maternal and child health promotion include an international financing facility, advance market commitments to fund research and development, a “De-Tax” to earmark a share of value-added taxes on goods and services for development, and voluntary solidarity contributions through electronic airline ticket sales or mobile phone contracts. Results-based funding as an incentive to achieve targets has also been considered by donors.

55. From the expense side, greater efficiency needs to be sought in funding programmes, including better alignment of donors’ investments with national priorities, and measures to reduce the cost of micronutrient supplements and ready-to-use therapeutic food, also by reducing patenting fees.

56. Financial monitoring and transparency in the use of resources will be needed for better accountability and increased efficiency.

57. **Proposed activities for Member States**

   (a) identify and map capacity needs, and include capacity-development in plans to expand nutrition actions;
   
   (b) implement a comprehensive approach to capacity building, including workforce development as well as leadership development, academic institutional strengthening, organizational development and partnerships;
   
   (c) cost the expansion plan and quantify the expected benefits, including the proportion needed for capacity development and strengthening the delivery of services;
   
   (d) provide support to local communities for the implementation of community-level nutrition actions;
   
   (e) establish a budget line and national financial targets for nutrition;
   
   (f) channel funds obtained from excise taxes to nutrition interventions.

58. **Proposed activities for the Secretariat**

   (a) support workforce development, leadership, technical and managerial capacities in nutrition in Member States through workshops, distance learning and communities of practice, and provision of training materials;
   
   (b) make available refined tools for capacity building, and support the capacity-building efforts of Member States;
   
   (c) provide costing tools for nutrition interventions.

59. **Proposed activities for international partners**

   (a) follow the principles of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, and align donor support at country level;
   
   (b) set international competency standards, specific to the development of the public health nutrition workforce, that recognize different tiers in the workforce (frontline workers, managers and specialists) and different contexts for policy (i.e. capacities for intersectoral action) and practice (i.e. the double burden of malnutrition), and support revisions of curricula for pre-service and in-service training of all levels of health workers;
   
   (c) establish academic alliances aimed at providing institutional support to capacity development in Member States;
(d) explore innovative financing tools for funding the expansion of nutrition programmes.

**ACTION 5: To monitor and evaluate the implementation of policies and programmes**

60. A well-defined monitoring framework is needed to assess progress made towards the objectives of the comprehensive implementation plan. The framework has to provide accountability for the actions implemented, resources and results. Table 3 lists proposed indicators for input (policy and legislative frameworks and human resources), output and outcome (nutrition programme implementation and food security) and impact (nutritional status and mortality).

61. The proposed set of indicators needs to be adapted to the country context and priorities, but will be retained for assessment purposes at the global level. Additional indicators should be considered for monitoring progress in intersectoral action.

62. Surveillance systems should be established to ensure regular flow of information to policy-makers. Reporting time should be in line with national priorities and the requirements of the governing bodies.\(^\text{112}\)

63. **Proposed activities for Member States**

   (a) develop or strengthen surveillance systems for the collection of information on selected input, output/outcome and impact indicators;

   (b) implement the WHO Child Growth Standards to monitor individual growth patterns and population levels of stunting, wasting and overweight;

   (c) ensure that nutrition indicators are adequately reported in the annual review process recommended by the Commission on Information and Accountability for Women’s and Children’s Health in countries with lowest income and highest burden of maternal and child deaths and that social differentials are adequately highlighted.

64. **Proposed activities for the Secretariat**

   (a) provide methodological support for the collection of selected input, output/outcome and impact indicators, including protocols and design of surveillance systems;

   (b) establish a database of selected input, output/outcome and impact indicators;

   (c) report on global progress in developing, strengthening and implementing national nutrition plans, policies and programmes;

   (d) support Member States in implementing the WHO Child Growth Standards.

65. **Proposed activities for international partners**

   (a) adopt the proposed framework of indicators as a tool to monitor the implementation of development activities;

   (b) support the collection and exchange of information between organizations, with the aim of ensuring global coverage of the databases of input, output/outcome and impact indicators.

\(^{112}\) Reporting implementation of the plan could be combined with the biennial reporting to the Health Assembly called for in Article 11.7 of the International Code of Marketing of Breast-milk Substitutes, adopted by the Health Assembly in resolution WHA34.22.
Table 1a. Effective direct nutrition interventions that can be expanded for delivery through the health system\textsuperscript{113}

<table>
<thead>
<tr>
<th>All women of reproductive age</th>
<th>Women in special circumstances</th>
<th>All children aged 0 to 24 months</th>
<th>Children in special circumstances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iron and folic acid supplementation - daily for pregnant women - intermittent in non-anaemic pregnant women - intermittent in menstruating women living in settings where anaemia is a public health concern</td>
<td>Appropriate care of women with low body mass index</td>
<td>Counselling and support for optimal breastfeeding (early initiation, exclusive breastfeeding for the first six months and continued breastfeeding up to two years of age or beyond)</td>
<td>Integrated management of severe acute malnutrition through facility- and community-based interventions</td>
</tr>
<tr>
<td>Nutritional care and support for HIV-infected pregnant and lactating women</td>
<td>Nutritional care and support in emergencies - multiple micronutrient supplementation for pregnant women</td>
<td>Implementation of the Baby-friendly Hospital Initiative</td>
<td>Nutritional care and support for HIV-positive children</td>
</tr>
<tr>
<td>Calcium supplementation for the prevention and management of pre-eclampsia and eclampsia</td>
<td>Iodine supplementation (in case iodized salt is unavailable)</td>
<td>Implementation of the International Code of Marketing of Breast-milk Substitutes and relevant resolutions of the World Health Assembly after resolution WHA34.22</td>
<td>Nutritional care and support in emergencies</td>
</tr>
<tr>
<td>Nutrition counselling through food-based dietary guidelines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{113} Based on individual country needs.
Table 1b. Effective health interventions with an impact on nutrition that can be expanded for delivery through the health system

<table>
<thead>
<tr>
<th>Women of reproductive age</th>
<th>Children aged 0 to 24 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention of adolescent pregnancy</td>
<td>Properly-timed cord clamping at birth</td>
</tr>
<tr>
<td>Pregnancy spacing</td>
<td>Deworming of children</td>
</tr>
<tr>
<td>Intermittent preventive treatment of malaria in pregnant women in high transmission areas</td>
<td>Intermittent preventive treatment of malaria in infants, in areas of high transmission in sub-Saharan Africa where plasmodial resistance to sulfadoxine-pyrimethamine is not high</td>
</tr>
<tr>
<td>Provision of insecticide-treated bednets</td>
<td>Provision of insecticide-treated bednets</td>
</tr>
<tr>
<td>Prevention of exposure to second-hand smoke and cessation of direct tobacco use, alcohol and drug consumption by pregnant women</td>
<td>Hand washing with soap, and other hygienic interventions</td>
</tr>
<tr>
<td>Reduction of indoor air pollution</td>
<td></td>
</tr>
<tr>
<td>Prevention and control of occupational risks in pregnancy</td>
<td></td>
</tr>
<tr>
<td>Prevention and control of genitourinary infections in pregnancy</td>
<td></td>
</tr>
<tr>
<td>Deworming of pregnant women</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children in special circumstances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iron supplementation for children aged under five years</td>
</tr>
<tr>
<td>Zinc supplementation for the management of diarrhoea</td>
</tr>
<tr>
<td>Nutrition counselling for the adequate care of sick children</td>
</tr>
<tr>
<td>Home fortification of foods intended for young children</td>
</tr>
<tr>
<td>Vitamin A administration as part of treatment for measles-related pneumonia for children older than six months</td>
</tr>
</tbody>
</table>
Table 2. Non-health interventions with an impact on nutrition

<table>
<thead>
<tr>
<th>Sector</th>
<th>Intervention</th>
</tr>
</thead>
</table>
| **Agriculture**      | Agricultural activities that generate employment  
|                      | Small-scale agriculture  
|                      | Production of nutrient-rich foods and of staple foods of the poor \(^{114}\)  
|                      | Home gardening and large-scale fruit and vegetable production  
|                      | Micronutrient-rich crop varieties (e.g. orange-flesh sweet potatoes)  
|                      | Diversified food production, and improved storage and processing of food  
|                      | Nutrition counselling integrated into agricultural extension programmes  
|                      | Women’s role in agriculture supported                                                                                                         |
| **Food manufacturing** | Local production of fortified foods, including fortified flour, oil, salt, sugar, soy and fish sauce, and fortified blended foods  
|                      | Local production of high nutritional quality complementary food with provisions to allow access to all sectors of the population  
|                      | Micronutrient fortification of complementary foods  
|                      | Salt iodization  
|                      | Improvement of the nutritional quality of foods (reduction of the content of salt, fats and sugars, and elimination of trans-fatty acids) |
| **Water and sanitation** | Improvement of water supply  
|                      | Improvement of sanitation                                                                                                                      |
| **Education**        | Women’s primary and secondary education  
|                      | Provision of healthy food in schools and pre-schools  
|                      | Nutrition and physical activity education in school                                                                                               |
| **Labour policies**  | Employment-support policies  
|                      | Healthy nutrition in the workplace  
|                      | Maternity protection in the workplace (through adopting and enforcing the ILO Maternity Protection Convention, 2000 (No. 183) and Recommendation (No. 191))  
|                      | Smoke-free workplaces                                                                                                                           |
| **Social protection** | Conditional cash transfers  
|                      | Unconditional cash transfers  
|                      | Support for socially disadvantaged groups to access healthy foods                                                                                   |
| **Urban planning**   | Healthy built environments                                                                                                                      |

<table>
<thead>
<tr>
<th>Sector</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade</td>
<td>Food-price regulatory measures</td>
</tr>
<tr>
<td></td>
<td>Agricultural subsidies</td>
</tr>
<tr>
<td></td>
<td>Offer of food in public institutions and private food outlets</td>
</tr>
<tr>
<td></td>
<td>Food-labelling schemes</td>
</tr>
<tr>
<td></td>
<td>Regulation of advertising food and beverages to children</td>
</tr>
<tr>
<td></td>
<td>Implementation of International Code of Marketing of Breast-milk substitutes</td>
</tr>
<tr>
<td>Finance</td>
<td>Use of excise taxes on tobacco and alcohol to finance expansion of nutrition programmes</td>
</tr>
<tr>
<td>Social mobilization</td>
<td>Social marketing for breastfeeding promotion, use of fortified foods, healthy diet and physical activity</td>
</tr>
</tbody>
</table>

Table 3. Indicators for monitoring the realization of the comprehensive implementation plan

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Outputs/outcomes</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy/strategy environment for nutrition: nutrition governance score</td>
<td>Prevalence of children aged under six months who are exclusively breastfed</td>
<td>Incidence of low birth weight</td>
</tr>
<tr>
<td>Human resources: ratio of community health workers to total population</td>
<td>Proportion of children aged under five years who have received two doses of vitamin A supplements¹¹⁵</td>
<td>Proportion of stunted children below five years of age</td>
</tr>
<tr>
<td>Legal frameworks: adoption and effective implementation of International Code of Marketing of Breast-milk Substitutes</td>
<td>Proportion of households with consumption of iodized salt</td>
<td>Proportion of wasted children below five years of age</td>
</tr>
<tr>
<td></td>
<td>Proportion of population with sustainable access to an improved water source</td>
<td>Proportion of thin women¹¹⁶ of reproductive age</td>
</tr>
<tr>
<td></td>
<td>Individual food consumption score</td>
<td>Proportion of children below five years of age with haemoglobin concentration of &lt;11 g/dl</td>
</tr>
<tr>
<td></td>
<td>Proportion of children receiving a minimum acceptable diet at 6-23 months of age</td>
<td>Proportion of women of reproductive age (15-49 years) with haemoglobin concentration of &lt;12 g/dl</td>
</tr>
<tr>
<td></td>
<td>Prevalence of children (aged 0-59 months) with diarrhoea who received oral rehydration therapy and therapeutic zinc</td>
<td>Median urinary iodine concentration (µg/l) in children aged 6-12 years</td>
</tr>
</tbody>
</table>

¹¹⁵ Children aged 6-59 months in settings where vitamin A deficiency is a public health problem.
¹¹⁶ Women with body mass index <18.5 kg/m².
Inputs | Outputs/outcomes | Impact |
--- | --- | --- |
Proportion of pregnant women receiving iron and folic acid supplements | Maternal mortality ratio (per 100 000 live births) | |
Infant mortality rate (per 1000 live births) | |
Under-five year mortality rate (per 10 000/day) | |

Document A65/12 (Report by the Secretariat):

**Nutrition of women in the preconception period, during pregnancy and the breastfeeding period**

1. In January 2012, the Executive Board at its 130th session took note of an earlier version of this report;\(^{117}\) the Board then adopted decision EB130(2).\(^{118}\)

2. The present report complements the report on a draft comprehensive implementation plan on maternal, infant and young child nutrition, which is submitted to the World Health Assembly separately.

3. There is a need to take a life-cycle approach and recognize the importance of optimal nutrition for women before they become pregnant in order to minimize the risks associated with malnutrition. Securing the good nutritional status of women across the life course will in the long term reduce intrauterine growth restriction, child underweight and stunting. Effective interventions to reduce low birth weight should focus on adequate nutrition of girls throughout their reproductive life, but start with appropriate infant and young child feeding and continue with adequate nutrition in later childhood and adolescence. The intergenerational cycle of malnutrition must be interrupted in order to eliminate stunting.

**NUTRITION OF WOMEN BEFORE THEY CONCEIVE**

4. About 468 million women aged 15 to 49 years (30% of all women)\(^{119}\) are thought to be anaemic, at least half because of iron deficiency. The highest proportions of these anaemic women live in Africa (48% to 57%), and the greatest numbers are in south-eastern Asia (182 million women of reproductive age and 18 million pregnant women). The prevalence of anaemia in adolescent girls (15-19 years) can be even higher and exceeds 60% in Ghana, Mali and Senegal.\(^{120}\) Anaemia and iron deficiency, which are associated with a lower physical capacity and increased susceptibility to infections, need to be tackled before women become pregnant in order to reduce the risks of poor maternal health and low birth weight babies.

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\(^{117}\) See documents EB130/11 and EB130/2012/REC/2, summary record of the second meeting.

\(^{118}\) See document EB130/2012/REC/1 for the decision, and for the financial and administrative implications for the Secretariat of the adoption of the decision.


5. Iodine and folic acid deficiencies in the periconceptional period (three months before and after conception) are associated with a higher prevalence of birth defects and mental retardation. The magnitude of folate deficiency throughout the world is poorly known: few countries have surveyed the folate status of at least one population group at the national level, and most national surveys have been conducted in the Americas and Europe. Every year worldwide, neural tube defects develop in about 300,000 pregnancies, and an adequate folic acid intake before and during early pregnancy would lower the incidence of those defects by 50% to 70%.

6. Low body mass index (<18.5 kg/m$^2$) and/or short stature (height <145 cm) are common in women in low-income countries, with the highest rates of the former observed in southern and south-eastern Asia, followed by sub-Saharan Africa, with “critical” rates (≥40%) in Eritrea and Bangladesh, and a “serious” (20% to 39%) prevalence in Cambodia, Chad, Ethiopia, India, Madagascar, Mali, Nepal and Yemen; most other countries have a prevalence of between 10% and 19%. More than 10% of women are shorter than 145 cm in Bangladesh, India and Nepal (in southern and south-eastern Asia) and Bolivia (Plurinational State of), Guatemala and Peru (in Latin America and the Caribbean). Maternal short stature and low body mass index independently have adverse effects on pregnancy outcomes: respectively, an increased risk of complications in pregnancy, the need for assisted delivery, and child’s low birth weight; and poor fetal physical development. Children born with low birth weight are at higher risk of mortality in the newborn period and of developing noncommunicable diseases such as type 2 diabetes and heart conditions in adulthood.

7. Conversely, about 35% of adult women worldwide are estimated to be overweight (body mass index ≥25 kg/m$^2$), a third of whom (297 million) are obese (body mass index ≥30 kg/m$^2$). In the European Region, the Eastern Mediterranean Region and the Region of the Americas this proportion exceeds 50%. The mean body mass index has increased over the past 20 years, leading to adverse metabolic effects on blood pressure, cholesterol and triglyceride concentrations, and insulin resistance, thereby increasing the risks of coronary heart disease, ischaemic stroke, type 2 diabetes and polycystic ovarian syndrome. Globally, 44% of the burden of disease due to diabetes, 23% of that due to ischaemic heart disease, and 7% to 41% for certain cancers, particularly breast cancer, are attributable to overweight and obesity. Breast cancer stands out as the most frequent type of cancer in women, in both high- and low-income countries.

8. More women enter pregnancy with a body mass index >30 kg/m$^2$, leading to an increased risk of complications during pregnancy and delivery. Their infants tend to be born larger and are at greater risk of becoming obese and developing type 2 diabetes as children and adolescents. These women also tend to retain more weight after birth.

9. In pregnant adolescents growth of the mother competes with that of the fetus, and the child’s birth weight is on average 200g lighter than that of children born to older mothers. Adolescent pregnancies represent up to 40% of first pregnancies in most countries with high rates of maternal and child undernutrition. Pregnancy may place an additional metabolic burden on obese adolescents.

**NUTRITION OF WOMEN DURING PREGNANCY**

10. During pregnancy a woman needs good nutritional status for a healthy outcome. Women who have a poor nutritional status at conception are at higher risk of disease and death; their health depends greatly on the availability of food, and they may be unable to cope with their increased nutrient needs during pregnancy in situations of food insecurity.

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Infections such as malaria and HIV and infestation with gastrointestinal parasites can exacerbate such women’s undernutrition.

11. A large number of women experience micronutrient deficiencies (of iron and vitamin A, for instance); almost half all pregnant women in the world are thought to have anaemia and 9.8 million pregnant women have night blindness. An estimated 19.1 million pregnant women (the highest proportions in Africa and south-eastern Asia) have low serum retinol concentrations. Maternal deficiencies in micronutrients may lower infant birth weight and jeopardize development and survival: maternal iodine deficiency is associated with congenital malformations and mental retardation in children, and a link between vitamin B12 deficiency and an increased risk of diabetes has been described in India. Insufficient intake of specific fatty acids, such as docosahexanoic acid, may also impede children’s development.

12. Obese women have an increased risk of complications in pregnancy, such as congenital malformations or pre-eclampsia. Compared with women with normal body mass index, they have higher plasma concentrations of glucose and their fetuses have higher insulin concentrations. Excessive weight gain during pregnancy has been observed frequently.

13. Maternal nutrition is a fundamental determinant of fetal growth, birth weight and infant morbidity; poor nutrition often leads to long-term, irreversible and detrimental consequences to the fetus.

**NUTRITION OF BREASTFEEDING WOMEN**

14. A woman’s lactational performance and the quality of her breast milk are not influenced by her weight, height or nutritional status, except that obese mothers may be less successful in breastfeeding. Macronutrient intake does not influence milk composition, but maternal fatty acid intake affects the fatty acid profile in breast milk. Breast-milk content of calcium, phosphorus, magnesium, sodium and potassium is not affected by maternal diet, but the content of several vitamins (A, D, thiamin, riboflavin, pyridoxine and cobalamin), iodine and selenium reflects maternal nutritional status and dietary intake. An adequate concentration of iodine in breast milk is essential for creating optimal stores of neonatal thyroid hormone and preventing impaired neurological development in breastfed neonates. Milk production may be reduced by alcohol consumption.

**NUTRITIONAL INTERVENTIONS TARGETING WOMEN BEFORE CONCEPTION AND DURING PREGNANCY AND BREASTFEEDING**

15. Despite considerable progress over the past decades, societies still fail to meet nutritional and other essential health needs of women, particularly in their adolescent years. Interventions to prevent and control the double burden of malnutrition can be established at various levels: direct nutrition interventions as well as health and non-health measures that have an impact on nutrition. Effective interventions applicable to all women and to women living in special circumstances are listed in Table 1a of the draft comprehensive implementation plan on maternal infant and young child nutrition.

16. Several specific health interventions that have an impact on women’s nutritional status exist, including pregnancy spacing, and prevention and treatment of both communicable and noncommunicable diseases, with measures ranging from provision of insecticide-treated bednets, vaccination (e.g. against rubella and hepatitis B) and deworming to hand washing, health promotion and treatment of depression.
17. Improving women’s nutrition needs action in sectors other than health. Social and economic interventions include universal women’s education, preferential treatment for minority groups, redistribution of resources (through welfare systems or cash transfers) and microcredit for women. In agriculture, actions include improving the nutritional quality of crops, investing in smallholders’ agriculture and developing technologies that raise productivity while safeguarding women’s time for child care. In order to reduce environmental hazards, potential interventions include provision of sanitation and clean water, elimination of vectors, and improved housing to prevent crowding and control indoor pollution. Maternity protection laws, such as the ILO Maternity Protection Convention, need to be implemented. Interventions that may reduce inequities in micronutrient status include legislation for food fortification, maximizing the opportunity of contacts with the health system (for example, delivery of supplements with vaccinations), education about infant and young child feeding, empowerment of women, cash transfers leading to improved child diets, and training staff in nutrition counselling. Many partners need to be engaged in the implementation of these programmes and policies, including governmental institutions, civil society and nongovernmental organizations.

18. In countries affected by disasters and crises, women are also often already chronically undernourished. Access to food and the maintenance of an adequate nutritional status are crucial determinants of women’s survival in a disaster. Women often play the major role in planning and preparation of food for their households. Following a disaster, household-livelihood strategies may change. Recognition of the distinct roles in family nutrition is central to improving food security at the household level.

19. Understanding the unique nutritional needs of pregnant and breastfeeding women is also important in developing appropriate food responses, and better preparedness would pave the way for better food security and nutrition responses in disasters. Such preparedness depends on the capabilities of, relationships between and knowledge held by governments, humanitarian agencies, local civil society organizations, communities and individuals, and their ability to anticipate and respond effectively to likely, imminent or current hazards. It covers contingency planning, stockpiling of equipment and supplies, emergency services and standby arrangements, communications, information management and coordination, personnel training and community-level planning.

FUTURE DIRECTIONS

20. Improving the health and nutritional status of women before conception and during pregnancy and breastfeeding requires a series of actions to raise the quality and increase the coverage of services, information about nutrition-related conditions, and the formulation of evidence-based policy and programme guidance. Suggested actions are mentioned in the draft comprehensive implementation plan on maternal infant and young child nutrition, but further activities could raise the profile of women’s nutrition. Specifically, Member States may consider expanding proven interventions targeting women’s nutrition in the health, agriculture, social protection, education and environmental sectors: raise the quality and increase the coverage of antenatal and postnatal care services; improve access to antenatal care of women with low socioeconomic status and other disadvantaged groups; monitor low birth weight, maternal undernutrition and obesity, weight gain in obese pregnant women and in those infected with HIV, maternal iron and folate status; develop and disseminate food-based dietary guidelines for pregnant women; make healthy diets and access to facilities for physical activity available and affordable; provide nutritional support to pregnant and lactating

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122 ILO Maternity Protection Convention 2000 (No. 183) and Recommendation (No. 191).
123 See document A65/11, Tables 1a and 1b.
women living with HIV; mount social-marketing campaigns to advocate healthy nutrition in the preconception period and for adolescents; run educational programmes and awareness campaigns to prevent adolescent pregnancy; and include specific provisions for women in preparedness plans for emergencies.

21. In addition, it is proposed that the Secretariat could:

- expand the evidence base, issue guidance on health and nutrition interventions that target women’s nutritional status, and disseminate that guidance through the WHO e-Library of Evidence for Nutrition Actions and the WHO Reproductive Health Library;
- produce model food-based dietary guidelines for pregnant women;
- include proven nutrition and health interventions with an impact on nutrition in the Integrated Management of Pregnancy and Childbirth and in preconceptual care;
- prepare guidance on optimal weight gain in pregnancy, indicators and cut-off points for folate deficiency.

**ACTION BY THE HEALTH ASSEMBLY**

22. The Health Assembly is invited to note the report.
Early marriages, adolescent and young pregnancies

1. In January 2012, the Executive Board at its 130th session considered an earlier version of this report. The present report has been modified to reflect a request by Board Members to include references to the linkages between early marriages and pregnancies and progress towards the health-related Millennium Development Goals, in particular towards Goal 5 (Improve maternal health), 4 (Reduce child mortality), 6 (Combat HIV/AIDS, malaria and other diseases), 2 (Achieve universal primary education) and 3 (Promote gender equality and empower women).

CURRENT GLOBAL SITUATION

2. In 2008, there were 16 million births to mothers aged 15-19 years, representing 11% of all births worldwide. About 95% of these births occurred in low- and middle-income countries. The global adolescent birth rate has declined from 60 per 1000 in 1990 to 48 per 1000 in 2007, with rates ranging from 5 per 1000 women in eastern Asia to 121 per 1000 in sub-Saharan Africa in 2007. Although adolescent birth rates are declining, the absolute number of births has declined less, owing to the increase in the adolescent population. Moreover, in many countries, the proportion of births (among women of all ages) that occur in adolescents has increased, because of the reduction of fertility in older women.

3. Pregnancies in and births to adolescents aged 10 to 14 years are relatively rare events in most countries; nevertheless in some sub-Saharan African countries the proportion of women who give birth before the age of 15 years has ranged from 0.3% to 12% since 2000, according to various sources. In Latin America, births in this age group represented less than 3% of all births among adolescents.

DETERMINANTS OF ADOLESCENT PREGNANCY

4. Most people initiate sexual activity between 15 and 19 years of age, boys earlier than girls, and there is no universal trend towards earlier sexual debut. In low-income countries, sexual activity for girls is often initiated within the context of marriage, or as a result of coercion, frequently with older men. The frequency of sexual activity is higher in adolescents who are in stable relationships - marriage or union - than in those who are not, hence the greater likelihood of pregnancy in the absence of contraception. However, having a child outside marriage is not uncommon in many countries. Latin America, the Caribbean, and high-income countries have higher rates of adolescent pregnancy outside marriage than southern Asia, and rates vary across sub-Saharan Africa.

5. Rates of use of contraception by adolescents are often low. Use of any contraceptive method in women aged 15-49 years who are married or in union has risen from 55% in 1990 to 63% in 2007. Among adolescents it is lower, but with large regional and country differences. A study of contraceptive use in married and unmarried adolescents in Latin American, European and Asian countries showed rates ranging between 42% and 68%. African countries have the lowest rates, ranging from 3% to 49%.

6. The latest international estimates indicate that worldwide more than 60 million women aged 20-24 years were married before the age of 18 years. The extent of early

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124 See documents EB130/12 and EB130/2012/REC/2, summary record of the third meeting.
marriage varies between countries and regions: the highest rates are found in West Africa, followed by southern Asia, northern Africa/the Middle East and Latin America. However, given southern Asia’s population size and rates of early marriage, about half the girls in early marriage live there. Data suggest that in most parts of the world the prevalence is decreasing but the pace is slow.

7. Gender norms shape the lives of girls and boys. These social expectations cover attitudes towards marriage and fertility, including, in some societies, early marriage, particularly for girls, and in others proof of fertility before unions are formalized. Expectations for boys may include gaining sexual experience as well as proving their fertility. Social norms that condone violence against women or girls put adolescent girls at risk of pregnancy and sexually transmitted infections, including HIV. Interventions to address gender norms in adolescence therefore contribute to the achievement of Goal 3 (Promote gender equality and empower women).

8. Lack of knowledge about sex and family planning and the lack of skills to put that knowledge into practice put adolescents at risk for pregnancy. Effective sexuality education is lacking in many countries. The one global measure of coverage related to sexuality education indicates that only 36% and 24%, respectively, of young men and young women aged 15-24 years in developing regions have comprehensive and correct knowledge of HIV/AIDS. Improved knowledge about sex and family planning will not only prevent early and unwanted pregnancies but also HIV infection and contribute to the attainment of Goal 6 (Combat HIV/AIDS, malaria and other diseases).

9. Education itself is a major protective factor for early pregnancy: the more years of schooling, the fewer early pregnancies. Although enrolment in primary schools has progressed over the past decades, low enrolment in secondary schools and vocational training limits young people’s potential, particularly girls. Birth rates among women with low education are higher than for those with secondary or tertiary education. Lower education levels are also associated with higher risks of maternal mortality: women, of all ages, with no education have a 2.6 times higher risk of maternal mortality than women with post-secondary education. In addition to preventing early pregnancies, improvements in educational levels among adolescent girls contribute to the attainment of Goal 2 (Achieve universal primary education).

10. Reproductive and maternal health agendas emphasize the right of all couples to have access to safe, effective, affordable and acceptable methods of fertility regulation and the right of women to access appropriate health-care services that enable them to go safely through pregnancy and childbirth. However, adolescents face unique barriers to health services. Many countries have laws that prohibit people less than 18 years of age from accessing sexual and reproductive health services without parental or spousal consent, effectively denying many sexually-active adolescents access to those services. Evidence suggests that training health workers, making small changes in facilities to make them more responsive to adolescents, and sensitizing the community are needed to reduce barriers and increase use of services by adolescents.

CONSEQUENCES OF EARLY PREGNANCY

11. First pregnancy at an early age is risky. Although births among adolescents account for 11% of all births worldwide, they account for 23% of the overall burden of disease (in terms of disability-adjusted life years) due to pregnancy and childbirth among women of all ages. In low- and middle-income countries, complications of pregnancy and childbirth are the leading cause of death in women aged 15-19 years. This is why the prevention of adolescent pregnancy is an effective intervention that contributes to Millennium Development Goal 5 (Improve maternal health). Early, unwanted pregnancies are
associated with increased levels of induced abortion, which when carried out in unsafe conditions carries severe health risks, including death. In 2008, there were an estimated three million unsafe abortions in developing countries among 15-19 year olds. Up to 65% of women with obstetric fistula developed this during adolescence, with dire consequences for their lives, physically and socially.

12. Adolescent pregnancy is also dangerous for the child: in low- and middle-income countries stillbirths and death in the first week and first month of life are 50% higher among babies born to mothers younger than 20 years than those born to mothers aged 20-29 years, and the younger the mother, the higher the risk. The rates of preterm birth, low birth weight and asphyxia are higher among the children of adolescent girls; all these conditions increase the chance of death or future health problems for the baby. Pregnant adolescent girls are more likely than older women to smoke and drink alcohol, practices that can contribute to stillbirth, low birth weight and other health problems in the child. By lowering child mortality, interventions to prevent early pregnancies also contribute to the attainment of Goal 4 (Reduce child mortality).

13. The social consequences of pregnancy in adolescence, particularly for unmarried girls, can be severe. School drop out and subsequent lower educational attainment not only hold back personal development but reduce women’s lifetime earnings and hence their contribution to economic growth. Pregnancies in unmarried girls sometimes provoke violence. Although reliable data on the scale of the problem are not available, pregnancy is increasingly recognized as a reason for suicide among pregnant girls. Similarly, pregnancy among unmarried girls in some cultures is reported as a ground for homicide, on the basis of maintaining family honour.

14. Early pregnancies are also associated with higher overall fertility rates. Reducing the number of early pregnancies and promoting adequate birth spacing contribute to lower total fertility rates. Lower total fertility rates, in turn, are associated with better health status of children.

PREVENTION OF EARLY PREGNANCY AND POOR REPRODUCTIVE OUTCOMES AMONG ADOLESCENTS

15. WHO has published the findings and recommendations of a systematic review on preventing too-early pregnancies and poor reproductive outcomes among adolescents in developing countries. The recommendations relate to (i) reducing marriage before the age of 18 years; (ii) reducing pregnancy before the age of 20 years; (iii) increasing the use of contraception by adolescents at risk of unintended pregnancy; (iv) reducing coerced sex among adolescents; (v) reducing unsafe abortion among adolescents; and (vi) increasing the use of skilled antenatal, childbirth and postnatal care among adolescents. The recommended actions are elaborated below.

16. Political leaders, planners and community leaders are encouraged to formulate and enforce laws and policies to prohibit the marriage of girls before the age of 18 years; to increase access to contraceptive information and services, including emergency contraceptives, for adolescents, especially those who are unmarried and those below a certain age; to improve coverage of sexuality education; to punish perpetrators of coerced sexual relations; to enable adolescents to obtain safe abortion care; and to expand the access of all women, including pregnant adolescents, to skilled antenatal, childbirth and postnatal care, including both basic and comprehensive emergency obstetric care.

17. Actions are needed to influence family and community norms related to delayed marriage; the retention of girls in schools, both at primary and secondary levels; the implementation of sexuality education and improvement of access to contraceptives for adolescents; and the censuring of coerced sex. Men and boys must be actively supported to question prevailing gender norms and stereotypes and the negative effects these norms and stereotypes can have on women, girls, families and communities.

18. Adolescent girls need to be informed and empowered to prevent pregnancy (and contracting sexually transmitted infections, including HIV). Sexuality education aims to equip children and adolescents with the knowledge, skills and values to make responsible choices about their sexual and social relationships. Similarly, adolescents need to be informed about safe abortion care, where legally available, and to be knowledgeable about the dangers of unsafe abortion. Adolescent girls need to develop their life skills, and improve their links to social networks and social supports that can help them to refuse unwanted sex and to resist coerced sex, actions that they often feel powerless to do.

19. The health sector needs to implement interventions to improve the delivery of health services to adolescents as a means of facilitating their access to and use of contraceptive information and services as well as skilled antenatal and childbirth care. Adolescents, their families and communities must be made aware of the importance of skilled antenatal and childbirth care. Service providers must show special sensitivity in dealing with adolescent girls. Pregnant adolescent girls must get the support they need to be well prepared for birth and birth-related emergencies; this includes creating a birthing plan that covers complications and emergencies during childbirth. Such preparedness must be an integral part of antenatal care for all pregnant adolescent girls, and should be maintained in households, communities and health facilities.

**ACTION BY THE HEALTH ASSEMBLY**

20. The Health Assembly is invited to note the report.
13.5 Monitoring of the achievement of the health-related Millennium Development Goals*

Document A65/14 (Report by the Secretariat):

Progress in the achievement of the health-related Millennium Development Goals, and global health goals after 2015

1. In response to requests in resolutions WHA63.15 and WHA63.24, this report summarizes the latest trends in progress towards achievement of the health-related Millennium Development Goals and specific targets. It also describes progress of the efforts to reduce child mortality through prevention and treatment of pneumonia, as requested in resolution WHA63.24, and to reduce perinatal and neonatal mortality. In addition, this report includes comments on the formulation of global health goals after 2015. An earlier version of this report was noted by the Executive Board at its 130th session.

CURRENT STATUS AND TRENDS

2. In 2011, more than a decade after world leaders adopted the Millennium Development Goals and their targets, substantial progress has been made in reducing child and maternal mortality, improving nutrition, and reducing morbidity and mortality due to HIV infection, tuberculosis and malaria. Progress in countries that have the highest rates of mortality has accelerated in recent years, even though large gaps persist between and within countries. The current trends form a good basis for intensified collective action and expansion of successful approaches to overcome the challenges posed by multiple crises and large inequalities.

3. Childhood malnutrition is the underlying cause of death in an estimated 35% of all deaths among children under five years of age. The proportion of such children in developing countries who were underweight is estimated to have declined from 29% to 18% between 1990 and 2010. This rate of progress is close to what is required to meet the relevant target but is unevenly distributed between and within regions.

4. Globally, significant progress has been made in reducing mortality in children under five years of age. Between 1990 and 2010, under-five mortality declined by 35%, from an estimated rate of 88 deaths per 1000 live births to 57. The global rate of decline has accelerated in the past decade, from 1.9% per annum between 1990 and 2000 to 2.5% per annum between 2000 and 2010. The annual rate of decline more than doubled in the African Region, where almost half all child deaths occur, rising from 1.1% to 2.6% over the same periods. Yet, most countries in this Region are not likely to achieve the target of a two-thirds reduction from 1990 levels of mortality by the year 2015. Globally, 37 out of 143 low- and middle-income countries will have reached that target by 2015 if the pace of progress remains the same as during the period 2005-2010.

126 The relevant specific targets are: for Goal 1, Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger; for Goal 4, Target 4.A: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate; for Goal 5, Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio; and Target 5.B: Achieve, by 2015, universal access to reproductive health; for Goal 6, Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS, Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it, and Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases; for Goal 7, Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking-water and basic sanitation; and for Goal 8, Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries.

127 See document EB130/2012/REC/2, summary records of the third meeting, section 3, and the fourth meeting.
5. In 2010, global measles immunization coverage was 85% among children aged 12-23 months. More countries are now achieving high levels of immunization coverage; in 2010, 65% of Member States reached at least 90% coverage, and in half WHO’s regions coverage of more than 90% was maintained. Between 2000 and 2010, the estimated number of measles deaths decreased by 74%, accounting for about one fifth of the overall decline in child mortality.

6. Nevertheless, nearly 20% of the deaths in children under the age of five years - mostly due to pneumonia and diarrhoeal diseases - continue to be preventable by vaccines. Efforts are being made to expand interventions against pneumonia, as called for by the Health Assembly in resolution WHA63.24 on accelerated progress towards achievement of Millennium Development Goal 4 to reduce child mortality: prevention and treatment of pneumonia, and against diarrhoeal diseases. A rapidly increasing number of countries in the African Region, the Region of the Americas and the Eastern Mediterranean Region have introduced pneumococcal conjugate vaccines in the past year with support from the GAVI Alliance. Joint statements by UNICEF and WHO on clinical management of children with diarrhoea and pneumonia have been used by several countries to formulate policies on increasing access to care through trained and supervised community health workers. By 2010, 30 out of 68 countries being monitored by the Countdown to 2015 initiative had adopted the policy on community case management of pneumonia and eight other countries moved towards adopting the policy in the course of 2010.

7. Although the reduction in maternal deaths has been noteworthy, down to an estimated 287,000 in 2010 from 543,000 in 1990, the rate of decline is just over half that necessary in order to achieve Target 5.A: reducing the maternal mortality ratio by three quarters between 1990 and 2015. The rate of decline in the maternal mortality ratio between 1990 and 2010 globally was 3.1% per annum, with lower rates in the Region of the Americas and the Eastern Mediterranean Region (22.5% and 2.6% per annum, respectively). Approximately a quarter of the countries with the highest maternal mortality ratio in 1990 (≥100 maternal deaths per 100,000 live births) have made insufficient or no progress.

8. In order to reduce maternal deaths, women need access to effective interventions and good-quality reproductive-health care. For the period 2005-2010, 63% of women aged 15 to 49 years who were married or in a consensual union were using some form of contraception. The proportion of women receiving antenatal care at least once during pregnancy was about 81% for the period 2005-2011, but the figure dropped to around 55% for the recommended minimum of four visits or more. The proportion of births attended by skilled personnel - crucial for reducing perinatal, neonatal and maternal deaths - was above 90% in three of the six WHO regions for the period of 2005-2011. However, improvements are needed in regions such as the African Region, where coverage is still under 50%.

9. The total number of neonatal deaths fell from 4.4 million in 1990 to 3.1 million in 2010. Neonatal mortality rates declined from 32 per 1000 live births to 23 per 1000 live births over the same period - a 28% reduction. This is a slower decline than for child mortality overall, and the proportion of deaths in children under five years old that occur in the neonatal period increased from 37% in 1990 to 40% in 2010. Progress in developing regions has been uneven, ranging from a 19% decline in sub-Saharan Africa and Oceania and 33% in southern Asia to more than 50% in northern Africa, Latin America and the Caribbean, and eastern Asia. The estimated global number of stillbirths fell from 3.0 million in 1995 to 2.6

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million in 2009, with the rate of stillbirths declining by about 15%, from 22 per 1000 births in 1995 to 19 per 1000 births in 2009.

10. Early postnatal care is crucial for the prevention and management of conditions that cause neonatal death. WHO and its partners are supporting the strengthening of the capabilities of health-care workers to prevent or manage the major perinatal and neonatal diseases, including home visits to newborn children. In addition, WHO is gathering more evidence on the most cost-effective interventions, including simpler antibiotic treatment regimens for treatment of neonatal sepsis.

11. About half the world’s population is at risk of malaria, and an estimated 216 million cases of malaria led to 655 000 deaths in 2010, 86% of which concerned children under the age of five years. In the WHO African Region, a total of eight countries and one area showed a reduction of more than 50% in either confirmed malaria cases or malaria admissions and deaths. In other WHO regions, the number of reported cases of confirmed malaria decreased by more than 50% in 35 of the 53 countries with ongoing transmission between 2000 and 2010 and downward trends of 25%-50% were seen in four other countries. The estimated incidence of malaria fell by 17% globally between 2000 and 2010. Coverage with interventions such as the distribution of insecticide-treated bednets and indoor residual spraying has greatly increased and needs to be sustained in order to prevent resurgence of disease and deaths.

12. The annual global number of new cases of tuberculosis has been slowly falling since 2006. In 2010, there were an estimated 8.8 million new cases, of which about 13% involved people living with HIV, and 5.7 million of these cases were reported by national tuberculosis programmes. In 2010, an estimated 1.1 million HIV-negative people died from tuberculosis, and an additional 350 000 died from HIV-associated tuberculosis. Mortality due to tuberculosis has fallen by just over one-third since 1990. In 2009, the treatment success rate reached 87% worldwide, the third successive year that the target of 85% (first set by the Health Assembly in 1991) has been exceeded. All WHO’s six regions are on track to achieve Target 6.C in terms of tuberculosis incidence rates falling by 2015. However, multidrug-resistant tuberculosis continues to pose problems.

13. Globally, in 2010, an estimated 2.7 million people were newly infected with HIV, 15% fewer than the 3.1 million people newly infected in 2001. In 22 countries in sub-Saharan Africa a similar rate of decline was observed during the past decade, but this region still accounted for 70% of all the people who acquired HIV infection globally. There were an estimated 34 million people living with HIV at the end of 2010, an increase from previous years. As access to antiretroviral therapy in low- and middle-income countries improves (16 times more people were treated in 2010 than in 2003), the population living with HIV will continue to grow since fewer people are dying from AIDS-related causes.

14. The term “neglected tropical diseases” covers a group of 17 diseases that are endemic in 149 countries, affecting more than a billion people. With the exception of dengue and leishmaniasis, these diseases rarely cause outbreaks and thrive in the poorest, most marginalized communities, causing severe pain, permanent disability and death. WHO has reached a turning point in its efforts to overcome these diseases thanks to a coordinated and integrated approach, adopted since 2007, involving the simultaneous use of multiple safe and high-quality donated medicines. With fewer than 1100 cases reported in 2011, dracunculiasis is on the verge of eradication without the use of any medication or vaccine.

129 The diseases concerned are: dengue, rabies, trachoma, Buruli ulcer, endemic treponematoses, leprosy, Chagas disease, human African trypanosomiasis, leishmaniasis, cysticercosis, dracunculiasis, echinococcosis, foodborne trematode infections, lymphatic filariasis, onchocerciasis, schistosomiasis and soil-transmitted helminthiases.
15. Work on drinking-water and basic sanitation is covered by Target 7.C, namely: to halve, by 2015, the proportion of the population without sustainable access to safe drinking-water. The world has met the Target with respect to drinking-water; in 2010, 89% of the population used an improved source of drinking-water compared with 76% in 1990. Progress has been impressive; nevertheless, disparities exist between WHO regions. Although coverage is above 90% in four of the six regions, it remains low in the African Region and Eastern Mediterranean Region. Based on the current rate of progress, these two regions will fall short of the 2015 target. With regard to basic sanitation, current rates of progress are too slow for the Target to be met, both globally and within WHO regions (with the exception of the Western Pacific Region). In 2010, 2,500 million people lacked access to improved sanitation facilities and 72% of these lived in rural areas. The number of people in urban areas without improved sanitation is increasing because of rapid growth in urban populations.

16. Although nearly all countries publish an essential medicines list, the availability of medicines at public health facilities is often limited. Surveys in more than 70 mainly low- and middle-income countries indicate that the average availability of selected generic medicines at health facilities was only 42% in the public sector and 64% in the private sector. The availability of medicines for treatment of chronic, noncommunicable diseases is particularly poor when compared with the availability of medicines for acute illness. In a study of 40 countries, the mean public sector availability of generic medicines for chronic noncommunicable diseases was 36%, while in the same facilities availability of medicines for acute illness was 53.5%. Lack of medicines in the public sector forces patients to purchase medicines privately, with generic medicines in the private sector costing on average 610% more than their international reference price. Such low public-sector availability and high private-sector prices drive many families - particularly those with a member suffering from a chronic noncommunicable disease - into catastrophic poverty.

GLOBAL HEALTH GOALS AFTER 2015

17. With just four years to go before the end of 2015, it is clear that much work remains to be done if the health-related Millennium Development Goals are to be achieved. At the same time, the world faces new challenges that need to be reflected in the way in which progress is measured after 2015. The views of Member States can help to shape the debate on this subject.

18. Unfinished business. Reporting on achievements has improved, but it will still be some time before achievement of the existing Goals can be fully assessed. It is clear, nevertheless, that many countries - particularly the poorest - will need sustained efforts beyond 2015 to enable the original Goals to be attained. Moreover, as gaps in income levels within and between countries persist or even widen, the focus on inequities and their consequences for health will also become sharper. One way to accelerate progress has been to focus on specific areas where achievements lag behind expectation. Examples include the United Nations Secretary-General’s Global Strategy for Women’s and Children’s Health, the recommendations of the United Nations Commission on Information and Accountability for Women’s and Children’s Health, and the Political Declaration on HIV/AIDS: intensifying our efforts to eliminate HIV/AIDS. The Rio Political Declaration on Social Determinants of Health specifically addresses the issue of inequity.

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131 See United Nations General Assembly resolution 65/277.
19. **New challenges to health.** All countries face common challenges relating to the health of their populations, many of which go beyond the health sector: rapid, unplanned urbanization; ageing populations; competition for scarce natural resources; economic uncertainty; migration; and the impact of climate on the fundamental requirements for health - clean air, safe and sufficient drinking-water; a secure food supply; and adequate nutrition and shelter. Epidemiological and demographic transitions impose an increasingly complex burden of infectious diseases in tandem with noncommunicable diseases, mental health disorders, injuries and the consequences of violence. Thus, while much unfinished business remains, countries have to face the growing challenges of chronic conditions. In September 2011, the United Nations General Assembly at its High-level Meeting on Prevention and Control of Non-communicable Diseases adopted a political declaration calling for a multipronged campaign by governments, industry and civil society to deal with the risk factors for major noncommunicable diseases. Specific indicators and targets to measure progress are under development.

20. **New approaches to development.** Thinking about development has changed. The Millennium Development Goals evolved, inter alia, through the series of United Nations thematic conferences in the 1990s when social goals were dominant. With the exception of Goal 8, they are primarily concerned with low-income countries. Many would now argue - in the face of challenges such as climate change and the impact of food and financial crises - that the goals need to be recast in ways that recognize development as a process that affects all societies, with indicators that can be used to measure overall global progress towards sustainable development.

21. **Defining new goals: the process.** The debate on development goals after 2015 has already begun and will feature prominently in forthcoming global meetings, in particular the Rio+20 United Nations Conference on Sustainable Development scheduled to be held on 13-22 June 2012. Within the United Nations system a Task Team, on which WHO is represented, is preparing a report to the Secretary General on the post-2015 development agenda. The Secretary will also appoint a High Level Panel to consider this issue after the completion of the Rio+20 Conference.

22. In defining new goals, it will be important to: identify measures of global progress towards sustainable development that go beyond the purely economic measures such as gross domestic product; give emphasis to the challenges of increasing employment and social protection; and create stronger links between economic, social and environmental policy (the three pillars of sustainable development). A broader conception of development should favour and not diminish the role of health. Health should therefore be cast as an important contributor to social, economic and environmental development, and, critically, as the benchmark for measuring the impact of policies in all areas.

23. **Learning from success.** The process of developing post-2015 goals that maintain a sense of focus while responding to new challenges will not be easy in the more complex political and institutional environment that exists today. In this regard, it is important to acknowledge the attributes of the current framework of the Millennium Development Goals that have contributed to its successes: a focus on a limited number of goals that resonate well with politicians and the general public, measurable indicators, and a defined timeline. Irrespective of the specific goals, similar attributes will be needed in the future if a new set of goals is to have the same degree of acceptance by a worldwide audience.

24. **The role of WHO.** Setting new health goals needs to be clearly linked with the process of WHO reform. WHO must be equipped to face new challenges and to complete

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133 See document EB130/6, Annex.
unfinished business. The purpose of this report is to stimulate discussion among Member States about how future goals for global health should be framed and measured. The expression of a common voice on the part of the health sector will exert a powerful influence on what will inevitably be a difficult and complex debate between parties in numerous sectors. At the same time, there needs to be congruence between the goals that Member States advocate for the world and the overall priorities for the Organization itself. In other words, the next set of health-related Millennium Development Goals should closely match the priorities to be defined in the next General Programme of Work.

**ACTION BY THE HEALTH ASSEMBLY**

25. The Health Assembly is invited to note the report and to provide further guidance.

**Document A65/15 (Report by the Secretariat):**

**Implementation of the recommendations of the Commission on Information and Accountability for Women’s and Children’s Health**

1. At its 130th session in January 2012 the Executive Board considered an earlier version of this report and adopted resolution EB130.R3.

2. The United Nations Secretary-General’s Global Strategy for Women’s and Children’s Health, launched in September 2010, called for WHO to coordinate a process to determine the most effective international institutional arrangements for ensuring global reporting, oversight and accountability on women’s and children’s health. In response, the Director-General established the Commission on Information and Accountability for Women’s and Children’s Health. The report of the Commission, of which the advance copy was released during the Sixty-fourth World Health Assembly in May 2011, was officially published during the United Nations General Assembly on 20 September 2011. The report presents 10 recommendations on monitoring, review and action for countries and globally, covering accountability for results and resources. This Secretariat report responds to the Health Assembly’s request in resolution WHA64.12 to the Director-General to report on progress achieved in connection with the agenda item concerning the Millennium Development Goals.

3. Implementation of the Global Strategy for Women’s and Children’s Health gained further momentum in 2011. WHO and its partners UNICEF, UNFPA, World Bank and UNAIDS in the H4+ interagency mechanism have facilitated the building of national commitments to the Global Strategy. Several commitments were announced at a technical briefing during the Sixty-fourth World Health Assembly in May 2011 and at the “Every Woman, Every Child” special event during the sixty-sixth session of the United Nations General Assembly in September 2011. All 49 lowest-income countries, which are the focus of the Global Strategy, have now made specific commitments to accelerate action towards the achievement of Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health).

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134 See documents EB130/14 and EB130/2012/REC/2, summary records of the third meeting, section 3; and the fourth meeting.

135 See document EB130/2012/REC/1 for the financial and administrative implications for the Secretariat of the adoption of the resolution.

4. WHO is working with its H4+ partners to support the realization of these national commitments. In practice, this implies support to the development of country plans or acceleration of the implementation of existing plans for maternal, newborn and child health interventions, and the linking of these efforts with activities to strengthen national health strategies and systems and with monitoring of maternal, newborn, child and adolescent health.

5. The Commission expanded the scope from the goal of 49 lowest-income countries set in the Global Strategy for Women’s and Children’s Health to 75 countries, by including an additional 26 countries that are part of the Countdown to 2015 initiative for tracking progress in maternal, newborn and child health. Together these 75 countries account for more than 95% of all maternal and child deaths in the world.

6. A consultation process organized by WHO with multiple stakeholders - United Nations bodies (notably those in the H4+ mechanism), global health partnerships (including the Partnership for Maternal, Newborn and Child Health, the Health Metrics Network and the GAVI Alliance), civil society organizations, country representatives, and academic and research institutions - has been conducted to translate the Commission’s 10 recommendations into a common strategic workplan. In November 2011 a meeting, organized by the Government of Canada and WHO, was held to clarify further the roles and responsibilities of the various partners and to learn from country practices. The country actions build on continuing activities and focus on strengthening monitoring of results, tracking of resources, civil registration and vital statistics systems, and maternal death review systems, facilitated by innovation through information and communication technology and eHealth systems. In addition, the aim of the meeting is to support the strengthening of country mechanisms for review, remedy and action related to national health strategies, in line with the approaches of the International Health Partnership and related initiatives, as well as advocacy and action for maternal, newborn and child health issues.

7. The Commission’s recommendations also indicate that global partners should support efforts by OECD to improve the latter’s creditor reporting system in order better to capture aid flows and financial data on maternal, newborn and child health. In addition, more efforts are needed to harmonize global reporting requirements, including alignment with the 11 indicators for maternal, newborn and child health proposed by the Commission, improved access to expanded global databases and analyses, and better tracking of resources for health. Disaggregated data by gender and other equity considerations will receive special attention.

8. WHO facilitated a process that led to the establishment of an independent expert review group, as recommended by the Commission, and is providing the secretariat for that group. The names of the seven members, including two co-chairs, were announced in September 2011. The first review will be conducted in 2012. The independent Expert Review Group will assess the extent to which all stakeholders honour their commitments to the Global Strategy and the Commission.

9. WHO and its partners have begun working with countries on a road map of priority activities to implement the Commission’s accountability framework during 2012–2015. By the end of February 16 Member States in the African Region had systematically assessed the current situation, and those assessments were being used to plan the priority actions for strengthening accountability for health in general and for women and children’s health in particular. The aim is to cover all 75 targeted countries with this process in 2012. By

January 2012, almost 30% of the US$ 88 million budget to support the implementation of the Commission’s recommendations had been pledged.

**ACTION BY THE HEALTH ASSEMBLY**

10. The Health Assembly is invited to note this report.

**RESOLUTION 13.5: Monitoring of the achievement of the health-related Millennium Development Goals**

**Executive Board Resolution EB130.R3**

**Monitoring the achievement of the health-related Millennium Development Goals: implementation of the recommendations of the Commission on Information and Accountability for Women’s and Children’s Health**

*The Executive Board, having considered the report on monitoring the achievement of the health-related Millennium Development Goals: implementation of the recommendations of the Commission on Information and Accountability for Women’s and Children’s Health, RECOMMENDS to the Sixty-fifth World Health Assembly the adoption of the following resolution:*

The Sixty-fifth World Health Assembly,

Recalling resolutions WHA63.15 on monitoring the achievement of the health-related Millennium Development Goals and WHA64.12 on WHO’s role in the follow-up to the United Nations High-level Plenary Meeting of the General Assembly on the Millennium Development Goals (New York, September 2010);

Expressing deep concern at the inadequate progress in achieving Millennium Development Goals 4 and 5 on reducing child mortality and on improving maternal health;

Acknowledging that much more needs to be done in achieving the Millennium Development Goals as progress has been uneven among regions and between and within countries, despite the fact that developing countries have made significant efforts;

Acknowledging the pledges and commitments made by a large number of Member States and partners to the United Nations Secretary-General’s Global Strategy “Every Woman Every Child” since it was launched in September 2010;

Welcoming the final report of the Commission on Information and Accountability for Women’s and Children’s Health and its set of bold recommendations for strengthening accountability for resources and results in women’s and children’s health;

Commending the work and contributions of the Commission on Information and Accountability for Women’s and Children’s Health, including in particular the development

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of an accountability framework built on three interconnected processes - monitoring, reviewing and acting;

Noting that the key recommendations relate to strengthening national accountability processes both with regard to resources as well as monitoring of results;

Welcoming the steps taken to implement the recommendations of the Commission on Information and Accountability for Women’s and Children’s Health, including the development of a multi-stakeholder workplan for the implementation of the accountability framework;

Welcoming the establishment of a global review mechanism which will report annually to the United Nations Secretary-General;

Reaffirming WHO’s key role in the implementation and follow-up of the recommendations of the Commission on Information and Accountability for Women’s and Children’s Health and acknowledging the crucial role of the Director-General in particular,

1. URGES Member States to honour their commitments to the United Nations Secretary-General’s Global Strategy for Women’s and Children’s Health and to further strengthen efforts to improve women’s and children’s health;

2. ALSO URGES Member States to implement the recommendations provided by the Commission on Information and Accountability for Women’s and Children’s Health to improve the accountability of results and resources by:

   (1) strengthening the accountability mechanisms for health in their own countries;

   (2) strengthening their capacity to monitor and evaluate progress and performance;

   (3) contributing to the strengthening and harmonization of existing international mechanisms to track progress on all commitments made;

3. REQUESTS the Director-General:

   (1) to work with and support Member States in implementing the full scope of the recommendations;

   (2) to ensure WHO’s effective engagement in collaboration with all stakeholders in the workplan to implement the Commission’s recommendations;

   (3) to provide support to the independent Expert Review Group in its work of assessing progress in the United Nations Secretary-General’s Global Strategy for Women’s and Children’s Health and implementation of the accountability framework;

   (4) to report annually until 2015 to the World Health Assembly through the Executive Board on progress achieved in the follow-up of the recommendations of the Commission on Information and Accountability for Women’s and Children’s Health in connection with the agenda item concerning the Millennium Development Goals.
13.6 Social determinants of health: outcome of the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, October 2011)*

Document A65/16 (Report by the Secretariat):

1. In January 2012 the Executive Board at its 130th session considered an earlier version of this report, adopted resolution EB130.R11, and requested the Secretariat to revise the report on the financial and administrative implications of the implementation of the resolution (see Annex).  

2. In 2009, the Health Assembly adopted resolution WHA62.14 on reducing health inequities through action on the social determinants of health. It requested the Director-General to provide support to Member States in measures that included convening a global event, with the assistance of Member States, before the Sixty-fifth World Health Assembly in order to discuss renewed plans for redressing the alarming trends of health inequities through actions on the social determinants of health. This report describes the process and outcome of the resulting event, the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 19-21 October 2011), and also summarizes progress on the implementation of resolution WHA62.14.

WORLD CONFERENCE ON SOCIAL DETERMINANTS OF HEALTH

3. WHO convened the World Conference on Social Determinants of Health in order to bring together Member States and stakeholders to share experiences and to build support for ways to implement policies and strategies to reduce health inequities. The World Conference, hosted by the Government of Brazil, also provided an opportunity for discussion about how the recommendations of the Commission on Social Determinants of Health™ could be implemented.

4. More than 1000 participants attended, including delegates from 125 Member States (with delegations in 54 cases led by ministers from the health, social development or other sectors), representatives from other organizations in the United Nations system and civil society, and technical experts. At the end of the meeting, the Rio Political Declaration on Social Determinants of Health was adopted.  

5. In preparation for the World Conference evidence was collected at the country level for analysis at the regional level, with the aim of reaching agreement on actions needed at the global level. Extensive consultations took place with Member States, United Nations bodies, civil society and academia. An Advisory Group, with representatives from Member States and experts, was appointed to support WHO in the planning of the Conference. Evidence from experiences in Member States was collected through a call for case studies, facilitated by the regional offices; findings of 28 case studies were analysed. Regional consultations of Member States and other key stakeholders were also organized through regional and intercountry meetings and discussions. A discussion paper on how countries can implement action on social determinants of health™ was written after several rounds of consultation with Member States, the Advisory Group, United Nations bodies, civil

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139 See documents EB130/15 and EB130/2012/REC/2, summary records of the fourth and eleventh meetings.
141 See resolution EB130.R11, Annex.
society, academia and the Secretariat. Part of the process was a public web consultation, which received 185 submissions.

6. The consultations identified five essential areas for action in a social-determinants approach to improving health, reducing inequities and promoting development. These areas formed the five themes of the World Conference, and were reviewed in the discussion paper. The Political Declaration calls for the implementation of a social-determinants-of-health approach to reduce health inequities and endorses the five priority action areas, calling for global and national actions within each of them. These action areas cover the following aspects.

(a) Better governance at the national level is needed for health and development. Good governance relating to social determinants involves transparent and inclusive decision-making processes that give voice to all concerned groups and sectors, and the formulation of feasible policies that have clear and measurable outcomes, build accountability and, crucially, are fair in both the way they are developed and the results they aim for.

(b) Participation in policy-making and implementation must be promoted. Participatory processes are important for effective governance regarding social determinants of health, particularly for empowering communities and enhancing the contribution of civil society, and ensuring that the needs of those most affected by health inequities are recognized.

(c) The health sector needs to be further reoriented towards reducing health inequities. Accessible, available, acceptable, affordable and high-quality health care and public health services are essential to the enjoyment of the highest attainable standard of health, one of the fundamental rights of every human being. The health sector should firmly act to reduce health inequities.

(d) Global governance and collaboration should be strengthened. International cooperation and solidarity for the equitable benefit of all people are important. Multilateral organizations have an important role in setting norms, articulating guidelines and identifying good practices for supporting actions on social determinants. They should also facilitate access to financial resources and technical cooperation, as well as review and, where appropriate, strategically modify policies and practices that undermine people’s health and well-being.

(e) Accountability and monitoring of progress need to be reinforced. Accountability mechanisms are essential to guide policy-making in all sectors, and need to take into account different national contexts. Monitoring trends in health inequities and the impacts of actions to redress them is crucial if significant progress is to be made. Information systems should facilitate the establishment of relationships between health outcomes and social stratification variables.

7. The Rio Political Declaration also calls upon WHO, other organizations in the United Nations system and other international organizations to advocate, coordinate and collaborate with Member States in the implementation of action in the five priority areas, recognizing that such global action will need increased capacity and knowledge within WHO and other multilateral organizations for the development and sharing of norms, standards and good practices. The Political Declaration therefore recommends that the social determinants approach is duly considered in WHO’s reform process, and that the Sixty-fifth World Health Assembly adopts a resolution endorsing the text.

PROGRESS IN IMPLEMENTING RESOLUTION WHA62.14 ON REDUCING HEALTH INEQUITIES THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH
8. The following summary responds to the request in resolution WHA62.14 to report on progress in implementing the resolution.

9. Since 2009, many Member States have implemented actions aimed at reducing health inequities through action on social determinants of health, often with support provided by the Secretariat at all three levels of the Organization. A few countries have been successful in making progress on inequities, but the successive global crises have exacerbated the challenges and increased inequities in many cases. It is urgent to intensify Member States’ commitment and work on social determinants of health in response to these crises, as was recognized at the World Conference.

10. The Secretariat, following the request of the Health Assembly, has undertaken several activities to provide support to Member States in their work on social determinants of health. These activities are summarized below.

11. **Working closely with partner agencies in the multilateral system.** The Secretariat has collaborated with other organizations in the United Nations system. WHO and UN-HABITAT jointly issued a report on urban health equity in 2010. Major contributions of the Secretariat in highlighting the importance of action on social determinants of health for tackling noncommunicable diseases included the joint organization of the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control, which resulted in the Moscow Declaration, and preparatory work for the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases, which likewise resulted in a Political Declaration. High-level representatives from ILO, UNICEF, UNDP, UNFPA and UNAIDS attended the World Conference, committing themselves to working together, and an informal United Nations platform on social determinants of health is currently being put in place with the aim of coordinating advocacy, research, capacity-building and joint technical assistance to Member States.

12. **Strengthening capacity within the Organization for prioritizing work on social determinants of health.** At all three levels of the Organization the Secretariat is integrating social determinants of health into its work. The WHO Country Cooperation Strategies guide specifically emphasizes the need for addressing social determinants of health and issues of equity, and provides guidelines for countries to work on those issues. Currently, work on social determinants of health is highlighted in more than 80 country cooperation strategies. WHO’s Priority Public Health Conditions Knowledge Network, an internal network involving 16 of the Organization’s programmes (including tuberculosis, child health, neglected tropical diseases, cardiovascular diseases, diabetes and other noncommunicable diseases), was convened in order to integrate a social determinants approach into WHO’s programmes. Through the network social determinants of health and health equity issues within those public health programmes were analysed, and strategic entry points for programmes to engage with other sectors on social determinants were identified. Various other WHO programmes have since integrated a social-determinants approach into their strategies, for example, the WHO Global health-sector strategy on HIV/AIDS 2011-2015 and in the Stop TB Strategy and its subsequent policy brief. The Secretariat has also supported the implementation of this integrated approach at country level, linked to primary health care.

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145 Resolution WHA64.14.
13. Providing support to Member States in implementing a health-in-all-policies approach. In 2010, WHO and the Government of South Australia jointly issued the Adelaide Statement on Health in All Policies, providing succinct advice on how to develop and strengthen that approach on the basis of equity. The health-in-all-policies approach resulted from consultations with Member States and experts, reflecting current thinking on policy formulation and ways to engage leaders and policy-makers in improving health equity. Commitments to both health-in-all-policies and multisectoral approaches to improving health and health equity have been facilitated by the Secretariat through advocacy and the use of its convening power. Health ministers from south-eastern Europe pledged to focus on Health Equity in All Policies at the Third Health Ministers’ Forum (Banja Luka, Bosnia and Herzegovina, 13 and 14 October 2011), and health ministers of the Pacific Island Countries committed themselves to adopting multisectoral action to improve health at the Ninth Meeting of Ministers of Health for the Pacific Island Countries (Honiara, Solomon Islands, 28 June–1 July 2011). More than 300 government leaders and city mayors committed themselves at the Global Forum on Urbanization and Health (Kobe, Japan, 15–17 November 2010) to the Kobe Call to Action for redressing urban health inequities. The Secretariat has launched Action: SDH, an internet community of practice to provide guidance, foster debate, and share experiences of actions aimed at improving health equity through dealing with the social determinants of health. The Secretariat has also published policy briefs on housing, education, transport, social protection and water, providing guidance on understanding the agendas of other sectors, identifying potential areas of collaboration, and highlighting the contribution that a social-determinants approach can make towards achieving the goals of other sectors.

14. Providing support to Member States in strengthening efforts on measurement and evaluation. The Global Health Observatory and WHO regional health observatories provide improved access to country data and scientifically sound information, including indicators of equity. Regional reports on health inequities and reports on urbanization and health, highlighting health inequity and potential multisectoral actions, have also been issued. Interactive atlases have been created in order to improve availability of and access to evidence on inequalities in health system performance, including data on quality of care and the structural determinants of such inequalities across countries and regions in Europe. A web-based resource of examples of health systems actions on socially determined health inequalities in Europe has also been developed. To be proactive in redressing health inequities in cities, the Secretariat has collaborated with the authorities in 17 cities in 10 countries to develop, pilot test and finalize the Urban Health Equity Assessment and Response Tool. This tool promotes the use of available data disaggregated by socioeconomic group and geographical area so as to enable formulation of policies and design of interventions to reduce health inequities.

15. Supporting research on effective policies and interventions to improve health equity. The Secretariat has enriched knowledge about effective policies and interventions

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that improve health equity as a result of addressing social determinants of health by preparing and widely disseminating numerous publications.\footnote{155}

16. Assessing the performance of existing global governance mechanisms to address the social determinants of health and reduce health inequities. In 2010, the Secretariat prepared a report for the Secretary-General on global health and foreign policy, including governance mechanisms.\footnote{156} The United Nations General Assembly in resolution 65/95 noted with appreciation the report and its recommendations. Regional offices have focused on regional governance mechanisms. In 2010, the Regional Office for Africa endorsed a regional strategy to address key determinants of health in the African Region in resolution AFR/RC60/R1. The Regional Office for Europe commissioned a regional review of the health divide and inequalities in health in 2010 in order to provide information for underpinning the new regional health policy. In its first phase the review has assessed the levels of inequalities in health across the European Region, identifying barriers to and opportunities for reducing them, and published an interim report in December 2010.\footnote{157} The resulting evidence informed the new European policy for health - Health 2020, which emphasizes reduction of health inequities in the 53 Member States in the Region.\footnote{158}

**ACTION BY THE HEALTH ASSEMBLY**

17. The Health Assembly is invited to adopt the resolution recommended by the Executive Board in resolution EB130.R11.

**ANNEX**

Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly

<table>
<thead>
<tr>
<th>1. Resolution: Outcome of the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 19-21 October 2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Linkage to the Programme budget 2012-2013 (see document A64/7 <a href="http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf">http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf</a>)</td>
</tr>
<tr>
<td>Strategic objective(s): 7 and 10 Organization-wide expected result(s): 7.1, 7.2, 7.3 and 10.5</td>
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</tbody>
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How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

The resolution would contribute to the achievement of the Organization-wide expected results mentioned above by requesting the Secretariat to scale up action on the social determinants of health, as identified in the Rio Political Declaration on Social Determinants of Health (2011).

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

No

\footnote{155}{Available from the WHO web site at www.who.int/social_determinants (accessed 24 February 2012).}
\footnote{156}{Document A/65/399.}
\footnote{157}{European Social Determinants and Health Divide Review. *Interim first report on social determinants of health and the health divide in the WHO European Region - executive summary.* Copenhagen, WHO Regional Office for Europe, 2010.}
\footnote{158}{Document EUR/RC61/9.}
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) 6 years (covering the period 2012–2017)
      (ii) Total: US$ 33.60 million (staff: US$ 10.90 million; activities: US$ 22.70 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$ 8.00 million (staff: US$ 3.60 million; activities: US$ 4.40 million)
      Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.
      Headquarters: US$ 1.30 million; regional offices: US$ 3.70 million; country offices: US$ 3.00 million
      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$ 8.00 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.
      In order to implement the resolution, six staff at grade P.4 and six at grade G.4 would be required at the country and regional levels, and one staff member at grade P.4 would be needed at headquarters.

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$ 8.00 million; source(s) of funds: voluntary contributions from countries, private donors and multilateral organizations.

RESOLUTION 13.6: Social determinants of health: outcome of the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, October 2011)

Executive Board Resolution EB130.R11

Outcome of the World Conference on Social Determinants of Health

The Executive Board, having considered the report on the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, October 2011), RECOMMENDS to the Sixty-fifth World Health Assembly the adoption of the following resolution:

The Sixty-fifth World Health Assembly,

159 Document EB130/15.
Having considered the report on the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 19-21 October 2011);

Reiterating our determination to take action on social determinants of health as collectively agreed by the World Health Assembly and reflected in resolution WHA62.14 on reducing health inequities through action on the social determinants of health, which notes the three overarching recommendations of the Commission on Social Determinants of Health: to improve daily living conditions; to tackle the inequitable distribution of power, money and resources; and to measure and understand the problem and assess the impact of action;

Recognizing the need to do more to accelerate progress in addressing the unequal distribution of health resources as well as conditions damaging to health at all levels;

Recognizing also the need to safeguard health of the populations regardless of global economic downturns;

Further acknowledging that health equity is a shared goal and responsibility and requires the engagement of all sectors of government, all segments of society, and all members of the international community, in “all-for-equity” and “health-for-all” global actions;

Recognizing the benefits of universal health coverage in enhancing health equity and reducing impoverishment;

Reaffirming the political will to make health equity a national, regional and global goal and to address current challenges - such as eradicating hunger and poverty; ensuring food and nutritional security, access to affordable, safe, efficacious and quality medicines as well as to safe drinking-water and sanitation, employment and decent work and social protection; protecting environments and delivering equitable economic growth through resolute action on social determinants of health across all sectors and at all levels;

Welcoming the discussions and results of the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 19-21 October 2011),

1. ENDORSES the Rio Political Declaration on Social Determinants of Health adopted by the World Conference on Social Determinants of Health, including as a key input to the work of Member States and WHO;

2. URGES Member States:

(1) to implement the pledges made in the Rio Political Declaration on Social Determinants of Health with regard to (i) better governance for health and development, (ii) promoting participation in policy-making and implementation, (iii) further reorienting the health sector towards reducing health inequities, (iv) strengthening global governance and collaboration, and (v) monitoring progress and increasing accountability;

(2) to develop and support policies, strategies, programmes and action plans that address social determinants of health, with clearly defined goals, activities and accountability mechanisms and with resources for their implementation;

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160 And, where applicable, regional economic integration organizations.
161 Attached as Annex.
162 And, where applicable, regional economic integration organizations.
(3) to support the further development of the health-in-all-policies approach as a way to promote health equity;

(4) to build capacities among policy-makers, managers, and programme workers in health and other sectors to facilitate work on social determinants of health;

(5) to give due consideration to social determinants of health as part of the deliberations on sustainable development, in particular in the United Nations Conference on Sustainable Development (Rio+20) and deliberations in other United Nations forums with relevance to health;

3. CALLS UPON the international community to support the implementation of the pledges made in the Rio Political Declaration on Social Determinants of Health for action on social determinants of health, including through:

(1) supporting the leading role of WHO in global health governance and promoting alignment of policies, plans and activities on social determinants of health with those of its partner organizations in the United Nations system, development banks and other key international organizations, including in joint advocacy, and in facilitating access to the provision of financial and technical assistance to countries and regions, in particular developing countries;

(2) strengthening international cooperation, with a view to promoting health equity in all countries, through facilitating transfer on mutually agreed terms of expertise, technologies and scientific data in the field of social determinants of health, as well as exchanging good practices for managing intersectoral policy development;

(3) facilitating access to financial resources;

4. URGES those developed countries which have pledged to achieve the target of 0.7% of gross national product for official development assistance by 2015, and those developed countries that have not yet done so, to make additional concrete efforts to fulfil their commitments in this regard, and also urges developing countries to build on progress achieved in ensuring that official development assistance is used effectively to help achieve development goals and targets;

5. REQUESTS the Director-General:

(1) to duly consider social determinants of health in the assessment of global needs for health, including in the WHO reform process and WHO’s future work;

(2) to provide support to Member States in implementing the Rio Political Declaration on Social Determinants of Health through approaches such as “health-in-all policies” in order to address social determinants of health;

(3) to work closely with other organizations in the United Nations system on advocacy, research, capacity-building and direct technical assistance to Member States for work on social determinants of health;

(4) to continue to convey and advocate the importance of integrating social determinants of health perspectives into forthcoming United Nations and other high-level meetings related to health and/or social development;
(5) to report to the Sixty-sixth and Sixty-eighth World Health Assemblies, through the Executive Board, on progress in implementing this resolution and the Rio Political Declaration on Social Determinants of Health.
ANNEX

Rio Political Declaration on Social Determinants of Health

*Rio de Janeiro, Brazil, 21 October 2011*

1. Invited by the World Health Organization, we, Heads of Government, Ministers and government representatives came together on the 21st day of October 2011 in Rio de Janeiro to express our determination to achieve social and health equity through action on social determinants of health and well-being by a comprehensive intersectoral approach.

2. We understand that health equity is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community, in an “all for equity” and “health for all” global action.

3. We underscore the principles and provisions set out in the World Health Organization Constitution and in the 1978 Declaration of Alma-Ata as well as in the 1986 Ottawa Charter and in the series of international health promotion conferences, which reaffirmed the essential value of equity in health and recognized 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”. We recognize that governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures and that national efforts need to be supported by an enabling international environment.

4. We reaffirm that health inequities within and between countries are politically, socially and economically unacceptable, as well as unfair and largely avoidable, and that the promotion of health equity is essential to sustainable development and to a better quality of life and well-being for all, which in turn can contribute to peace and security.

5. We reiterate our determination to take action on social determinants of health as collectively agreed by the World Health Assembly and reflected in resolution WHA62.14 (“Reducing health inequities through action on the social determinants of health”), which notes the three overarching recommendations of the Commission on Social Determinants of Health: to improve daily living conditions; to tackle the inequitable distribution of power, money and resources; and to measure and understand the problem and assess the impact of action.
6. Health inequities arise from the societal conditions in which people are born, grow, live, work and age, referred to as social determinants of health. These include early years' experiences, education, economic status, employment and decent work, housing and environment, and effective systems of preventing and treating ill health. We are convinced that action on these determinants, both for vulnerable groups and the entire population, is essential to create inclusive, equitable, economically productive and healthy societies. Positioning human health and well-being as one of the key features of what constitutes a successful, inclusive and fair society in the 21st century is consistent with our commitment to human rights at national and international levels.

7. Good health requires a universal, comprehensive, equitable, effective, responsive and accessible quality health system. But it is also dependent on the involvement of and dialogue with other sectors and actors, as their performance has significant health impacts. Collaboration in coordinated and intersectoral policy actions has proven to be effective. Health In All Policies, together with intersectoral cooperation and action, is one promising approach to enhance accountability in other sectors for health, as well as the promotion of health equity and more inclusive and productive societies. As collective goals, good health and well-being for all should be given high priority at local, national, regional and international levels.

8. We recognize that we need to do more to accelerate progress in addressing the unequal distribution of health resources as well as conditions damaging to health at all levels. Based on the experiences shared at this Conference, we express our political will to make health equity a national, regional and global goal and to address current challenges, such as eradicating hunger and poverty, ensuring food and nutritional security, access to safe drinking water and sanitation, employment and decent work and social protection, protecting environments and delivering equitable economic growth, through resolute action on social determinants of health across all sectors and at all levels. We also acknowledge that by addressing social determinants we can contribute to the achievement of the Millennium Development Goals.

9. The current global economic and financial crisis urgently requires the adoption of actions to reduce increasing health inequities and prevent worsening of living conditions and the deterioration of universal health care and social protection systems.

10. We acknowledge that action on social determinants of health is called for both within countries and at the global level. We underscore that increasing the ability of global actors, through better global governance, promotion of international cooperation and development; participation in policy-making and monitoring progress, is essential to contribute to national and local efforts on social determinants of health. Action on social determinants of health should be adapted to the national and sub-national contexts of individual countries and regions to take into account different social, cultural and economic systems. Evidence from research and experiences in implementing policies on social determinants of health, however, shows common features of successful action. There are five key action areas critical to addressing health inequities: (i) to adopt better governance for health and development; (ii) promote participation in policy-making and implementation; (iii) to further reorient the health sector towards reducing health inequities; (iv) to strengthen global governance and collaboration; and (v) to monitor progress and increase accountability. Action on social determinants of health therefore means that we, the representatives of Governments, will strive individually and collectively to develop and support policies, strategies, programmes and action plans, which address social determinants of health, with the support of the international community, that include:

11. To adopt better governance for health and development

11.1 Acknowledging that governance to address social determinants involves transparent and inclusive decision-making processes that give voice to all groups and sectors involved, and develop policies that perform effectively and reach clear and measurable outcomes, build accountability, and, most crucially, are fair in both policy development processes and results;
11.2 We pledge to:

(i) Work across different sectors and levels of government, including through, as appropriate, national development strategies, taking into account their contribution to health and health equity and recognizing the leading role of health ministries for advocacy in this regard;

(ii) Develop policies that are inclusive and take account of the needs of the entire population with specific attention to vulnerable groups and high-risk areas;

(iii) Support comprehensive programmes of research and surveys to inform policy and action;

(iv) Promote awareness, consideration and increased accountability of policy-makers for impacts of all policies on health;

(v) Develop approaches, including effective partnerships, to engage other sectors in order to identify individual and joint roles for improvements in health and reduction of health inequities;

(vi) Support all sectors in the development of tools and capacities to address social determinants of health at national and international levels;

(vii) Foster collaboration with the private sector, safeguarding against conflict of interests, to contribute to achieving health through policies and actions on social determinants of health;

(viii) Implement resolution WHA62.14, which takes note of the recommendations of the final report of the Commission on Social Determinants of Health;

(ix) Strengthen occupational health safety and health protection and their oversight and encourage the public and private sectors to offer healthy working conditions so as to contribute to promoting health for all;

(x) Promote and strengthen universal access to social services and social protection floors;

(xi) Give special attention to gender-related aspects as well as early child development in public policies and social and health services;

(xii) Promote access to affordable, safe, efficacious and quality medicines, including through the full implementation of the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property;

(xiii) Strengthen international cooperation with a view to promoting health equity in all countries through facilitating transfer on mutually agreed terms of expertise, technologies and scientific data in the field of social determinants of health, as well as exchange of good practices for managing intersectoral policy development.

12. To promote participation in policy-making and implementation

12.1 Acknowledging the importance of participatory processes in policy-making and implementation for effective governance to act on social determinants of health;
12.2 We pledge to:

(i) Promote and enhance inclusive and transparent decision-making, implementation and accountability for health and health governance at all levels, including through enhancing access to information, access to justice and public participation;

(ii) Empower the role of communities and strengthen civil society contribution to policy-making and implementation by adopting measures to enable their effective participation for the public interest in decision-making;

(iii) Promote inclusive and transparent governance approaches, which engage early with affected sectors at all levels of governments, as well as support social participation and involve civil society and the private sector, safeguarding against conflict of interests;

(iv) Consider the particular social determinants resulting in persistent health inequities for indigenous people, in the spirit of the United Nations Declaration on the Rights of Indigenous Peoples, and their specific needs and promote meaningful collaboration with them in the development and delivery of related policies and programmes;

(v) Consider the contributions and capacities of civil society to take action in advocacy, social mobilization and implementation on social determinants of health;

(vi) Promote health equity in all countries particularly through the exchange of good practices regarding increased participation in policy development and implementation;

(vii) Promote the full and effective participation of developed and developing countries in the formulation and implementation of policies and measures to address social determinants of health at the international level.

13. To further reorient the health sector towards reducing health inequities

13.1 Acknowledging that accessibility, availability, acceptability, affordability and quality of health care and public health services are essential to the enjoyment of the highest attainable standard of health, one of the fundamental rights of every human being, and that the health sector should firmly act to reduce health inequities;

13.2 We pledge to:

(i) Maintain and develop effective public health policies which address the social, economic, environmental and behavioural determinants of health with a particular focus on reducing health inequities;

(ii) Strengthen health systems towards the provision of equitable universal coverage and promote access to high quality, promotive, preventive, curative and rehabilitative health services throughout the life-cycle, with a particular focus on comprehensive and integrated primary health care;

(iii) Build, strengthen and maintain public health capacity, including capacity for intersectoral action, on social determinants of health;

(iv) Build, strengthen and maintain health financing and risk pooling systems that prevent people from becoming impoverished when they seek medical treatment;

(v) Promote mechanisms for supporting and strengthening community initiatives for health financing and risk pooling systems;
(vi) Promote changes within the health sector, as appropriate, to provide the capacities and tools to act to reduce health inequities including through collaborative action;

(vii) Integrate equity, as a priority within health systems, as well as in the design and delivery of health services and public health programmes;

(viii) Reach out and work across and within all levels and sectors of government by promoting mechanisms for dialogue, problem-solving and health impact assessment with an equity focus to identify and promote policies, programmes, practices and legislative measures that may be instrumental for the goal pursued by this Political Declaration and to adapt or reform those harmful to health and health equity;

(ix) Exchange good practices and successful experiences with regard to policies, strategies and measures to further reorient the health sector towards reducing health inequities.

14. **To strengthen global governance and collaboration**

14.1 Acknowledging the importance of international cooperation and solidarity for the equitable benefit of all people and the important role the multilateral organizations have in articulating norms and guidelines and identifying good practices for supporting actions on social determinants, and in facilitating access to financial resources and technical cooperation, as well as in reviewing and, where appropriate, strategically modifying policies and practices that have a negative impact on people's health and well-being:

14.2 We pledge to:

(i) Adopt coherent policy approaches that are based on the right to the enjoyment of the highest attainable standard of health, taking into account the right to development as referred to, inter alia, by the 1993 Vienna Declaration and Programme of Action, that will strengthen the focus on social determinants of health, towards achieving the Millennium Development Goals;

(ii) Support social protection floors as defined by countries to address their specific needs and the ongoing work on social protection within the United Nations system, including the work of the International Labour Organization;

(iii) Support national governments, international organizations, nongovernmental entities and others to tackle social determinants of health as well as to strive to ensure that efforts to advance international development goals and objectives to improve health equity are mutually supportive;

(iv) Accelerate the implementation by the State Parties of the WHO Framework Convention on Tobacco Control (FCTC), recognizing the full range of measures including measures to reduce consumption and availability, and encourage countries that have not yet done so to consider acceding to the FCTC as we recognize that substantially reducing tobacco consumption is an important contribution to addressing social determinants of health and vice versa;

(v) Take forward the actions set out in the political declaration of the United Nations General Assembly High-Level Meeting on the Prevention and Control Noncommunicable Diseases at local, national and international levels – ensuring a focus on reducing health inequities;

(vi) Support the leading role of the World Health Organization in global health governance, and in promoting alignment in policies, plans and activities on social determinants of health with its partner United Nations agencies, development banks and other key international organizations, including in joint advocacy, and in facilitating access to the provision of financial and technical assistance to countries and regions;
[vii] Support the efforts of governments to promote capacity and establish incentives to create a sustainable workforce in health and in other fields, especially in areas of greatest need;

[viii] Build capacity of national governments to address social determinants of health by facilitating expertise and access to resources through appropriate United Nations agencies’ support, particularly the World Health Organization;

[ix] Foster North-South and South-South cooperation in showcasing initiatives, building capacity and facilitating the transfer of technology on mutually agreed terms for integrated action on health inequities, in line with national priorities and needs, including on health services and pharmaceutical production, as appropriate.

15. **To monitor progress and increase accountability**

15.1 Acknowledging that monitoring of trends in health inequities and of impacts of actions to tackle them is critical to achieving meaningful progress, that information systems should facilitate the establishment of relationships between health outcomes and social stratification variables and that accountability mechanisms to guide policy-making in all sectors are essential, taking into account different national contexts;

15.2 We pledge to:

(i) Establish, strengthen and maintain monitoring systems that provide disaggregated data to assess inequities in health outcomes as well as in allocations and use of resources;

(ii) Develop and implement robust, evidence-based, reliable measures of societal well-being, building where possible on existing indicators, standards and programmes and across the social gradient, that go beyond economic growth;

(iii) To promote research on the relationships between social determinants and health equity outcomes with a particular focus on evaluation of effectiveness of interventions;

(iv) Systematically share relevant evidence and trends among different sectors to inform policy and action;

(v) Improve access to the results of monitoring and research for all sectors in society;

(vi) Assess the impacts of policies on health and other societal goals, and take these into account in policy-making;

(vii) Use intersectoral mechanisms such as a Health In All Policies approach for addressing inequities and social determinants of health; enhance access to justice and ensure accountability, which can be followed up;

(viii) Support the leading role of the World Health Organization in its collaboration with other United Nations agencies in strengthening the monitoring of progress in the field of social determinants of health and in providing guidance and support to Member States in implementing a Health In All Policies approach to tackling inequities in health;

(ix) Support the World Health Organization on the follow-up to the recommendations of the Commission on Information and Accountability for Women’s and Children’s Health;
Promote appropriate monitoring systems that take into consideration the role of all relevant stakeholders including civil society, nongovernmental organizations as well as the private sector, with appropriate safeguards against conflict of interests, in the monitoring and evaluation process;

Promote health equity in and among countries, monitoring progress at the international level and increasing collective accountability in the field of social determinants of health, particularly through the exchange of good practices in this field;

Improve universal access to and use of inclusive information technologies and innovation in key social determinants of health.

16. Call for global action

16.1 We, Heads of Government, Ministers and government representatives, solemnly reaffirm our resolve to take action on social determinants of health to create vibrant, inclusive, equitable, economically productive and healthy societies, and to overcome national, regional and global challenges to sustainable development. We offer our solid support for these common objectives and our determination to achieve them.

16.2 We call upon the World Health Organization, United Nations agencies and other international organizations to advocate for, coordinate and collaborate with us in the implementation of these actions. We recognize that global action on social determinants will need increased capacity and knowledge within the World Health Organization and other multilateral organizations for the development and sharing of norms, standards and good practices. Our common values and responsibilities towards humanity move us to fulfill our pledge to act on social determinants of health. We firmly believe that doing so is not only a moral and a human rights imperative but also indispensable to promote human well-being, peace, prosperity and sustainable development. We call upon the International Community to support developing countries in the implementation of these actions through the exchange of best practices, the provision of technical assistance and in facilitating access to financial resources, while reaffirming the provisions of the United Nations Millennium Declaration as well as the Monterrey Consensus of the International Conference on Financing for Development.

16.3 We urge those developed countries which have pledged to achieve the target of 0.7 percent of GNP for official development assistance by 2015, and those developed countries that have not yet done so, to make additional concrete efforts to fulfill their commitments in this regard. We also urge developing countries to build on progress achieved in ensuring that official development assistance is used effectively to help achieve development goals and targets.

16.4 World leaders will soon gather again here in Rio de Janeiro to consider how to meet the challenge of sustainable development laid down twenty years ago. This Political Declaration recognizes the important policies needed to achieve both sustainable development and health equity through acting on social determinants.

16.5 We recommend that the social determinants approach is duly considered in the ongoing reform process of the World Health Organization. We also recommend that the 65th World Health Assembly adopts a resolution endorsing this Political Declaration.
13.10 Poliomyelitis: intensification of the global eradication initiative*

Document A65/20 (Report by the Secretariat):

1. In 2008, the Sixty-first World Health Assembly in resolution WHA61.1 requested the Director-General to develop a new strategy to reinvigorate the fight to eradicate poliomyelitis. The ensuing Global Polio Eradication Initiative Strategic Plan 2010-2012 was subsequently launched in June 2010 and, in keeping with the guidance from the Executive Board, an Independent Monitoring Board was established to monitor the situation by reference to the milestones in the Strategic Plan. This report provides an update, as at mid-February 2012, on progress towards - and challenges to reaching – the Strategic Plan’s milestones, summarizes the Independent Monitoring Board’s concerns regarding the risks to completing eradication, and proposes next steps for the Global Polio Eradication Initiative.

2. Cases of paralytic poliomyelitis due to wild polioviruses declined by 52% in 2011 compared with 2010 (649 cases compared with 1352 cases). Cases due to the serotype 1 wild poliovirus declined by 54% (582 cases compared with 1265), and cases due to the serotype 3 wild poliovirus declined by 23% (67 cases compared with 87 cases). Of the four countries with endemic transmission of wild poliovirus, India met its end-2011 milestone of stopping virus circulation, its most recent case having onset of paralysis on 13 January 2011. Of the four countries with “re-established” poliovirus transmission, South Sudan has not had a case since 27 June 2009. Angola had a substantial decrease in new cases in 2011 and may also have stopped transmission, with its most recent case having onset of paralysis on 7 July 2011. In Chad and the Democratic Republic of the Congo, intensive transmission in early 2011 declined substantially in the second half of the year, following corrective actions taken by both countries. Of eight countries with outbreaks of poliomyelitis due to new importations of wild poliovirus in 2011, all but one such outbreak, in Mali, were stopped within six months. As at mid-February 2012, three of these new outbreaks were ongoing, though for less than six months, in the Central African Republic (most recent case 8 December 2011), China (9 October 2011) and Niger (12 December 2011). One outbreak from 2010 persisted into 2011 and for more than 12 months on the border between Kenya (most recent case 30 July 2011) and Uganda.

3. By contrast, in Afghanistan, Nigeria and Pakistan, the other three countries with endemic transmission of wild poliovirus, there was a significant increase in new cases in 2011 compared with 2010, particularly in the second half of the year. Nigeria saw a 185% increase in cases, especially in the northern states of Kano, Jigawa, Borno and Sokoto (62 cases compared with 21 cases for the same period in 2010, 44 of which are from the four northern states mentioned). Afghanistan and Pakistan experienced a 220% and 37% increase in cases, respectively (80 cases compared with 25 cases, and 198 cases compared with 144 cases, respectively). Furthermore, Nigeria and Pakistan were the only countries in the world with confirmed type 3 wild poliovirus circulation since September 2011. Nigeria is the only country in the world with re-established transmission of a type 2 circulating vaccine-derived poliovirus. In 2011, wild polioviruses originating in Nigeria and Pakistan were also associated with outbreaks in previously polio-free countries.

4. Since December 2010, the Independent Monitoring Board has met quarterly and provided recommendations to the heads of agency of the Global Polio Eradication Initiative’s spearheading partners and the Bill & Melinda Gates Foundation. In April 2011,

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163 Documents EB126/2010/REC/2, summary record of the thirteenth meeting, section 4A, and EB128/35 Add.1, section C.
164 Data available at www.polioeradication.org/Dataandmonitoring/Poliotrivial.aspx (accessed 20 March 2012). All case data are reported to WHO through national acute flaccid paralysis surveillance systems.
the Independent Monitoring Board stated that “Completing the eradication of polio is a global health emergency”. In October 2011, the Independent Monitoring Board reaffirmed that assessment, but expressed conviction that “polio can - and must - be eradicated,” and highlighted issues at the global, cross-programme and country-specific levels that urgently needed to be addressed, especially “accountability and its enforcement at all levels of the programme”. In November 2011, the Strategic Advisory Group of Experts on immunization endorsed the findings of the Independent Monitoring Board, concluding unequivocally “that the risk of failure to finish global polio eradication constitutes a programmatic emergency of global proportions for public health and is not acceptable under any circumstances”. The World Health Organization Regional Committee for Africa in August 2011 adopted resolution AFR/RC61/R4, in which it urged Member States to declare the persistence of polio a national public health emergency. The Executive Board at its 130th session considered an earlier version of this report and adopted resolution EB130.R10 on 21 January 2012, declaring the completion of poliovirus eradication a programmatic emergency for global public health.

5. In response to the evolving polio epidemiology in 2011 and Executive Board resolution EB130.R10, the Governments of Nigeria and Pakistan developed or augmented their national emergency action plans for polio eradication, and the Head of Government in each country appointed a focal point to oversee national efforts and established a monitoring mechanism to hold local authorities accountable for the performance and quality of activities. The Global Polio Eradication Initiative intensified its extensive programme of work, initiated following the October 2011 Independent Monitoring Board report, to strengthen accountability processes, promote innovation, ensure critical real-time evaluation of eradication plans in key infected areas, deepen stakeholder engagement, and reduce outbreak risks. A Global Polio Emergency Action Plan 2012-2013 was developed to support Afghanistan, Nigeria and Pakistan in implementing corrective actions to achieve, by end-2012, the coverage levels needed to interrupt poliovirus transmission in each of the remaining infected areas. The plan draws heavily on lessons learnt in all infected areas, particularly India, in 2010-2011, on the recommendations of the Independent Monitoring Board, and on recent innovations for enhancing programme implementation and impact. The plan also commits partner agencies, particularly WHO and UNICEF, to deploy substantial additional surge support to enable strategy implementation in priority infected areas.

6. In its February 2012 report, the Independent Monitoring Board highlighted that the emergency approach must be extended to front-line workers, especially in Pakistan and Nigeria which “represent the gravest risk to global eradication”. The Independent Monitoring Board stated that “An emergency approach involves considering every measure that can help. This should include, for example, the possibility of using the International Health Regulations to limit the potential spread from affected countries”. Already in the first quarter of 2012, however, an insufficiency of financing required some emergency eradication activities to be scaled back in 24 at-risk countries. The Global Polio Eradication Initiative continues to engage with the international development community to close the financing gap for 2012-2013 which, at February 2012, stood at US$ 1090 million against an overall budget of US$ 2230 million.

7. In line with the development of the Global Polio Emergency Action Plan 2012-2013, a new, more efficient medium-term strategy is being examined, which would combine the eradication of residual wild poliovirus transmission with the polio “endgame” strategy.

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166 Document EB130/19.
The latter had been designed to deal with vaccine-derived polioviruses, but only after certification of wild poliovirus eradication. The new strategy is based on new diagnostic tests for vaccine-derived polioviruses, the availability of bivalent oral poliovirus vaccine, and new low-cost approaches for the use of inactivated poliovirus vaccine. The Strategic Advisory Group of Experts on immunization endorsed the central premise of the new strategy: in summary, the removal of Sabin polioviruses from immunization programmes should be phased, beginning with the particularly problematic Sabin type 2 poliovirus in the near term, followed by the remaining serotypes, after certification of wild poliovirus eradication globally. This approach could facilitate the eradication of the remaining wild polioviruses types 1 and 3 (by replacing all trivalent oral poliovirus vaccine with the more efficacious bivalent oral poliovirus vaccine) and allow action to be taken to control any new type 2 circulating vaccine-derived polioviruses during the period that global surveillance and response capacity is highest. Substantial planning is required for a globally synchronized switch from trivalent to bivalent oral poliovirus vaccine for routine immunization and, potentially, the introduction beforehand of one or more doses of inactivated poliovirus vaccine. In 2012, the Strategic Advisory Group of Experts on immunization will provide recommendations on the actual implementation of this strategy based on broad-based consultations across a number of work streams.

ACTION BY THE HEALTH ASSEMBLY

8. The Health Assembly is invited to adopt the resolution recommended by the Executive Board in resolution EB130.R10.

RESOLUTION 13.10: Poliomyelitis: intensification of the global eradication initiative

Executive Board Resolution EB130.R10

The Executive Board, having considered the report on poliomyelitis: intensification of the Global Polio Eradication Initiative, recommends to the Sixty-fifth World Health Assembly the adoption of the following resolution:

The Sixty-fifth World Health Assembly,

Having considered the report on poliomyelitis: intensification of the Global Polio Eradication Initiative;

Recalling resolution WHA61.1 on poliomyelitis: mechanism for management of potential risks to eradication, which, inter alia, requested the Director-General to develop a new strategy to reinvigorate the fight to eradicate poliovirus and to develop appropriate strategies for managing the long-term risks of reintroduction of poliovirus and re-emergence of poliomyelitis, including the eventual cessation of use of oral poliovirus vaccine in routine immunization programmes;

168 In 2011, there were six outbreaks due to a circulating vaccine-derived poliovirus in seven countries; five were due to the type 2 serotype. Fifty-six of the 58 cases due to these circulating vaccine-derived polioviruses were caused by the type 2 serotype. Data are available at https://www.polioeradication.org/Dataandmonitoring/Poliothisweek/Circulatingvaccine derivedpoliovirus.aspx (accessed 20 March 2012).

169 See document EB130/19 Add.1 for the financial and administrative implications for the Secretariat of adoption of the resolution.
Recognizing the need to make rapidly available the necessary financial resources to eradicate the remaining circulating polioviruses and to minimize the risks of reintroduction of poliovirus and re-emergence of poliomyelitis after interruption of wild poliovirus transmission;

Noting the Independent Monitoring Board’s recent finding that “polio simply will not be eradicated unless it receives a higher priority - in many of the polio-affected countries, and across the world” and its recommendation that the World Health Assembly “considers a resolution to declare the persistence of polio a global health emergency”;

Noting the recent report of the Strategic Advisory Group of Experts on immunization that “states unequivocally that the risk of failure to finish global polio eradication constitutes a programmatic emergency of global proportions for public health and is not acceptable under any circumstances”;

Recognizing the need for Member States to engage all levels of political and civil society in order to ensure all children are vaccinated to eradicate poliomyelitis;

Noting that the technical feasibility of poliovirus eradication has been proved through the full application of new strategic approaches;

Noting that continuing poliovirus transmission anywhere will continue to pose a risk to poliomyelitis-free areas until such time as all poliovirus transmission is interrupted globally;

1. DECLARES the completion of poliovirus eradication a programmatic emergency for global public health, requiring the full implementation of current and new eradication strategies, the institution of strong national oversight and accountability mechanisms for all areas infected with poliovirus, and the application of appropriate vaccination recommendations for all travellers to and from areas infected with poliovirus;  

2. URGES Member States with poliovirus transmission to declare such transmission to be a “national public health emergency” making poliovirus eradication a national priority programme, requiring the development and full implementation of emergency action plans, to be updated every six months, until such time as poliovirus transmission has been interrupted;

3. URGES all Member States:

   (1) to eliminate the unimmunized areas and to maintain very high population immunity against polioviruses through routine immunization programmes and, where necessary, supplementary immunization activities;

   (2) to maintain vigilance for poliovirus importations, and the emergence of circulating vaccine-derived polioviruses, by achieving and sustaining certification-standard surveillance and regular risk assessment for polioviruses;

   (3) to urgently make available the financial resources required for the full and continued implementation through end-2013 of the necessary strategic approaches to interrupt wild poliovirus transmission globally, and to initiate planning for the financing to the end of 2018 of the polio endgame strategy;

(4) to engage in multilateral and bilateral cooperation, including exchanging epidemic information, laboratory monitoring data, and carrying out supplementary immunization activities simultaneously as appropriate;

4. REQUESTS the Director-General:

(1) to plan for the renewed implementation through 2013 of the approaches for eradicating wild polioviruses outlined in the Global Polio Eradication Initiative Strategic Plan 2010-2012 and any new tactics that are deemed necessary to complete eradication, including the enhancement of the existing global polio eradication initiative within the Organization;

(2) to strengthen accountability and monitoring mechanisms to ensure optimal implementation of eradication strategies at all levels;

(3) to undertake the development, scientific vetting, and rapid finalization of a comprehensive polio eradication and endgame strategy that exploits new developments in poliovirus diagnostics and inactivated poliovirus vaccines, informs Member States of the potential timing of a switch from trivalent to bivalent oral poliovirus vaccine for all routine immunization programmes, and includes budget scenarios to the end of 2018 that include risk management;

(4) to coordinate with all the relevant partners to promote the research, production and supply of vaccines, to enhance their affordability, effectiveness and accessibility;

(5) to continue mobilizing and deploying the necessary financial and human resources for the strategic approaches required through 2013 for wild poliovirus eradication, and for the eventual implementation of a polio endgame strategy to the end of 2018;

(6) to report to the Sixty-sixth World Health Assembly and the subsequent two Health Assemblies, through the Executive Board, on progress in implementing this resolution.
13.11 Elimination of schistosomiasis*

Document A65/21 (Report by the Secretariat):

1. The Executive Board at its 130th session in January 2012 considered an earlier version of this report; the Board then adopted resolution EB130.R9.

2. Schistosomiasis remains of significant public health importance, with an estimated 200 million people infected worldwide, 90% of whom live in sub-Saharan Africa. The disease is caused by blood flukes *Schistosoma haematobium*, *S. guineensis*, *S. intercalatum*, *S. japonicum*, *S. mansoni*, and *S. mekongi*. *S. haematobium* causes urogenital schistosomiasis whereas the other forms cause intestinal disease.

3. In 2001, the Health Assembly, in resolution WHA54.19 on schistosomiasis and soil-transmitted helminth infections, urged Member States inter alia: (1) to sustain successful control activities in low-transmission areas in order to eliminate schistosomiasis and soil-transmitted helminth infections as a public health problem, and to give high priority to implementing or intensifying control of schistosomiasis and soil-transmitted helminth infections in areas of high transmission while monitoring drug quality and efficacy; (2) to ensure access to essential drugs against schistosomiasis and soil-transmitted helminth infections in all health services in endemic areas for the treatment of clinical cases and groups at high risk of morbidity such as women and children, with the goal of attaining a minimum target of regular administration of chemotherapy to at least 75% and up to 100% of all school-age children at risk of morbidity by 2010; (3) to promote access to safe water, sanitation and health education through intersectoral collaboration; (4) to ensure that any development activity likely to favour the emergence or spread of parasitic diseases is accompanied by preventive measures to limit their impact; and (5) to mobilize resources in order to sustain activities for control of schistosomiasis and soil-transmitted helminthiasis.

4. Overall, that goal was not attained. In 2010, only 12.2% of people at risk of schistosomiasis morbidity and 22.8% of school-age children at risk of morbidity due to soil-transmitted helminthiasis benefitted from preventive chemotherapy with praziquantel and with benzimidazoles, respectively. Global supplies of praziquantel are insufficient, and this lack of praziquantel is the major barrier to schistosomiasis control in many endemic countries. Provision of hygiene, sanitation and potable water to at-risk populations has been inadequate in many countries.

5. Progress was, however, made in expanding schistosomiasis control; the number of those benefitting from preventive chemotherapy with praziquantel rose from 12 million in 2006 to 33.5 million in 2010. This increase was due to greater access to large-scale treatment, for instance through donations of praziquantel and provision of more resources by multiple partners for the control of neglected tropical diseases. The establishment of schistosomiasis control programmes showed that expansion of interventions to national level is feasible in resource-constrained countries. Large-scale schistosomiasis treatment was carried out in 28 countries endemic for the disease in 2010, and several African countries in which the disease is highly endemic achieved morbidity control and have substantially lower levels of transmission. They request guidance on how to proceed towards elimination.

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172 See document EB/130/2012/REC/2, summary record of the tenth meeting, section 1.
173 See document EB130/2012/REC/1 for the resolution, and for the financial and administrative implications for the Secretariat of the adoption of the resolution.
6. In the past few years, several countries classified as endemic for schistosomiasis have reported no new autochthonous cases. Schistosomiasis transmission may therefore be interrupted. Among these countries are the Islamic Republic of Iran, Japan, Jordan, Mauritius, Morocco, Tunisia, and some Caribbean countries and territories. In China, among the 12 provinces in which schistosomiasis has been endemic, five have eliminated the disease and three more have recently achieved targets set for its control. In a few countries in which schistosomiasis is endemic, transmission may be sufficiently low for elimination to be feasible.

7. In Morocco, for example, in 1982 the Ministry of Health launched a national schistosomiasis control programme, whose goal was changed in 1994 to eliminating the disease by 2004. The last autochthonous case of schistosomiasis in the country was detected in 2003. Serological surveys carried out in 2009 confirmed the interruption of S. haematobium transmission.\(^1\)\(^7\) Tools for assessment and confirmation of the interruption of schistosomiasis transmission were validated in those surveys.

8. The Secretariat considers that elimination, as envisaged in resolution WHA54.19, is feasible in some epidemiological settings, provided that: there is strong political commitment to the goal; supplies of anthelminthic medicines for preventive chemotherapy are adequate; and support for hygiene, sanitation and water is provided by Member States and the international community.

9. For countries with a high burden of disease, interventions need to be scaled up in order to reduce the morbidity due to schistosomiasis. In countries with control programmes in operation efforts should be intensified to consolidate gains made and to reduce the transmission of schistosomiasis.

10. Where possible, schistosomiasis control measures should be integrated into other disease control programmes and into health systems in order to make efficient use of resources and optimize programme benefits.

11. With progress being made in eliminating schistosomiasis and the validation in some countries of instruments for confirming interruption of transmission, consideration needs to be given to assessing, on request, that the disease has been eliminated from a country.

**ACTION BY THE HEALTH ASSEMBLY**

12. The Health Assembly is invited to adopt the resolution recommended by the Executive Board in resolution EB130.R9.

**RESOLUTION 13.11: Elimination of schistosomiasis**

**Executive Board Resolution EB130.R9**

*The Executive Board, having considered the report on elimination of schistosomiasis,*\(^1\)\(^7\)\(^6\)*RECOMMENDS to the Sixty-fifth World Health Assembly the adoption of the following resolution:*\(^1\)\(^7\)\(^7\)


\(^1\)\(^6\) Document EB130/20.

\(^1\)\(^7\) See document EB130/20 Add.1 for the financial and administrative implications for the Secretariat of adoption of the resolution.
The Sixty-fifth World Health Assembly,

Having considered the report of the Secretariat on the elimination of schistosomiasis;

Recalling resolutions WHA3.26, WHA28.53, WHA29.58 and WHA54.19 on schistosomiasis;

Noting the resolution EM/RC54/R.3 on neglected tropical diseases: an emerging public health problem in the Eastern Mediterranean Region, adopted by the Regional Committee for the Eastern Mediterranean, which called on Member States, inter alia, to sustain successful control activities in low-transmission areas in order to eliminate schistosomiasis;

Expressing concern that schistosomiasis remains a major public health problem in countries endemic for the disease, and that the goal set in resolution WHA54.19 of attaining a minimum target of regular administration of chemotherapy to at least 75% of school-age children at risk of morbidity was not achieved by 2010;

Noting the extension in coverage of treatment of schistosomiasis from 12 million in 2006 to 32.6 million people in 2010, and the greater access to praziquantel as a result of donations and increased support from partners to endemic countries for neglected tropical diseases control;

Congratulating Member States, the Secretariat and partners for increasing access to praziquantel and resources to scale up schistosomiasis control;

Encouraged that some countries endemic for schistosomiasis have interrupted its transmission;

Congratulating those countries endemic for schistosomiasis that, with strengthened control programmes and surveillance, have reported no new autochthonous cases of schistosomiasis,

1. CALLS ON all countries endemic for schistosomiasis:

   (1) to attach importance to prevention and control of schistosomiasis, analyse and develop applicable plans with progressive targets, intensify control interventions and strengthen surveillance;

   (2) to take full advantage of non-health programmes to improve the environment, in order to cut the transmission of schistosomiasis and accelerate the elimination of the intermediate host;

   (3) to ensure the provision of essential drugs;

2. URGES Member States, the Secretariat and partners to provide support to countries endemic for schistosomiasis to expand control programmes;

3. REQUESTS the Director-General:

   (1) to encourage Member States and the international community to make available the necessary and sufficient means and resources, particularly medicines, and water, sanitation, and hygiene interventions, to intensify control programmes in most endemic countries and initiate elimination campaigns, where appropriate;
(2) to prepare guidance for Member States in order to determine when to initiate elimination campaigns, along with methods for implementation of programmes and documentation of success;

(3) to assess, on request, the interruption of transmission in the appropriate Member States, to analyse the global status of schistosomiasis prevention and control, the epidemic model, and key challenges, so as to provide targeted recommendations and guidance;

(4) to report every three years through the Executive Board, to the World Health Assembly, on progress in implementing this resolution.
13.12 Draft global vaccine action plan*

Document A65/22  (Report by the Secretariat):

1. In May 2011, a report by the Secretariat on the global immunization vision and strategy was noted by the Sixty-fourth World Health Assembly. During the discussions the vision for the Decade of Vaccines (2011-2020) and the development of a global vaccine action plan were welcomed. Subsequently, the Executive Board at its 130th session in January 2012 considered the draft global vaccine action plan and provided guidance. The Board also adopted resolution EB130.R12 on World Immunization Week. The present document provides an updated draft of the action plan that draws on an extensive consultation process, and invites consideration of a draft resolution in relation to the plan.

INTRODUCTION

2. The draft global vaccine action plan builds on the success of the Global Immunization Vision and Strategy, 2006-2015, which was launched in 2005 as the first 10-year strategic framework to realize the potential of immunization. Developing the plan has brought together multiple stakeholders involved in immunization, including governments and elected officials, health professionals, academia, manufacturers, global agencies, development partners, civil society, media and the private sector, to define collectively what the immunization community wants to achieve over the next decade. In total, the global consultation process reached over 1100 individuals representing more than 140 countries and 290 organizations, and included two special sessions to brief representatives of the Permanent Missions of the United Nations Offices and other Intergovernmental Organizations in Geneva and New York.

3. Immunization is, and should be recognized as, a core component of the human right to health and an individual, community and governmental responsibility. Vaccination prevents an estimated 2.5 million deaths each year. Protected from the threat of vaccine-preventable diseases, immunized children have the opportunity to thrive and a better chance of realizing their full potential. These advantages are further increased by vaccination in adolescence and adulthood. As part of a comprehensive package of interventions for disease prevention and control, vaccines and immunization are an essential investment in a country’s - indeed, in the world’s - future.

4. Now is the time for showing commitment to achieving the full potential of immunization. The collective recognition of this opportunity has led the global health community to call for a Decade of Vaccines, in line with the requests made in resolution WHA61.15 on the global immunization strategy. The vision for the Decade of Vaccines (2011-2020) is of a world in which all individuals and communities enjoy lives free from vaccine-preventable diseases. The mission of the Decade of Vaccines is to extend, by 2020 and beyond, the full benefit of immunization to all people, regardless of where they are born, who they are or where they live.

5. The draft global vaccine action plan reiterates existing goals and sets new goals for the decade, proposes six strategic objectives and the actions that will support their achievement, and provides an initial estimate of resource requirements and return on investment. Annex 1 summarizes recommended indicators to monitor and evaluate progress. Beyond the action plan, country, regional and global stakeholders need to take

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178 See documents A64/14 and WHA64/2011/REC/2, summary records of the sixth meeting, section 2, the seventh meeting and the eighth meeting, section 2.
179 See documents EB130/21 and EB130/2012/REC/2, summary record of the eleventh meeting.
180 See document EB130/2012/REC/1 for the resolution, and for the financial and administrative implications for the Secretariat of the adoption of the resolution.
responsibility for specific actions, translate the action plan into detailed operational plans (updating both the action plan and the operational plans as new information becomes available), complete the development of an accountability framework for the Decade of Vaccines (2011-2020) and mobilize resources to ensure that the vision for the Decade of Vaccines becomes a reality. Accomplishing this will require global and national institutions to innovate and to change the way they work. Annex 2 provides a summary of stakeholder responsibilities.

6. The last century was, in many respects, the century of treatment, resulting in dramatic reductions in morbidity and mortality, with the discovery and use of antibiotics as one of the biggest agents of change in health. This century promises to be the century of vaccines, with the potential to eradicate, eliminate or control a number of serious, life-threatening or debilitating infectious diseases, and with immunization at the core of preventive strategies. Ensuring that the vision for the Decade of Vaccines becomes a reality is a powerful step in that direction.

THE IMMUNIZATION LANDSCAPE TODAY

Important progress in the last decade

7. In the last 10 years, great advances have been made in developing and introducing new vaccines and expanding the reach of immunization programmes. More people than ever before are being vaccinated and access and use of vaccines by age groups other than infants is expanding. As a result of immunization combined with other health care and development interventions – including improved access to clean water and sanitation, better hygiene and education – the annual number of deaths among children under five years of age fell from an estimated 9.6 million in 2000 to 7.6 million in 2010, despite an increase in the number of children born each year.

8. Immunization has helped drive this reduction in child mortality: coverage of vaccines that have been in use since the inception of the Expanded Programme on Immunization has expanded, and new vaccines have been introduced. Vaccines against hepatitis B and Haemophilus influenzae type b have become part of national immunization schedules in 179 and 173 countries, respectively; poliomyelitis is nearing eradication; and a large number of deaths from measles are being averted every year. The number of deaths caused by traditional vaccine-preventable diseases (diphtheria, measles, neonatal tetanus, pertussis and poliomyelitis) has fallen from an estimated 0.9 million in 2000 to 0.4 million in 2010.\footnote{Sources for estimates: measles and neonatal tetanus, in World Health Statistics 2012, Geneva, World Health Organization, 2012; diphtheria and poliomyelitis, for 2000: http://www.who.int/healthinfo/global_burden_disease/estimates_regional_2000_v3/en/index.html (accessed 5 April 2012), for 2008: http://apps.who.int/ghodata/ (accessed 5 April 2012); pertussis, WHO Secretariat provisional data.}

9. New and increasingly sophisticated vaccines that have become available in the last decade, including pneumococcal conjugate vaccine and vaccines against infection with rotavirus and human papillomavirus, are currently being rolled out globally. Efforts are being made to shorten the time lag that has historically existed in the introduction of new vaccines between high- and low-income countries. For example, the 13-valent pneumococcal conjugate vaccine was introduced in a low-income country a little more than a year after it had been introduced in a high-income country.

10. Through an innovative international collaboration, an affordable conjugate vaccine against Neisseria meningitidis serogroup A was developed and is now in use in the African meningitis belt. There are now licensed vaccines being used to prevent, or contribute to the prevention and control of, 25 vaccine-preventable infections (Table 1).
Table 1: Vaccine-preventable infectious agents or diseases

- Anthrax
- Cholera
- Diphtheria
- Hepatitis A
- Hepatitis B
- Hepatitis E
- *Haemophilus influenzae* type b
- Human papillomavirus
- Japanese encephalitis
- Measles
- Meningococcal disease
- Mumps
- Pertussis
- Pneumococcal disease
- Poliomyelitis
- Rabies
- Rotavirus gastroenteritis
- Rubella
- Influenza
- Tetanus
- Tuberculosis
- Typhoid fever
- Tick-borne encephalitis
- Varicella and herpes zoster (shingles)
- Yellow fever

11. The strengthening by countries of national programmes, aided by improved support from and coordination among local, national, regional and international stakeholders, has succeeded in improving immunization coverage rates. Financing from domestic budgets allocated to immunization programmes has risen over the past decade, as has the flow of international resources dedicated to immunization. According to the immunization programme data for 2010, 154 of the 193 Member States report having a specific budget line item for immunization, and 147 have developed multi-year national plans to sustain the gains achieved, further enhance performance to reach desired goals and introduce appropriate new vaccines.

12. Global and regional immunization initiatives have supported countries in building up their systems and introducing new vaccines. Global goals and milestones established through the Global Immunization Vision and Strategy 2006-2015, the United Nations Millennium Declaration, the United Nations World Summit for Children, the United Nations General Assembly Special Session on Children, and, more recently, the United Nations Secretary-General’s Global Strategy for Women’s and Children’s Health have stimulated expansion of national immunization programmes. In low- and middle-income countries these have been supported by initiatives such as the GAVI Alliance, the Global Polio Eradication Initiative, the Measles Initiative, the vaccine procurement services of UNICEF, and PAHO’s Revolving Fund for Vaccine Procurement.

**Significant unmet needs remain**

13. Despite this progress, vaccine-preventable diseases remain a major cause of morbidity and mortality. Adoption of new vaccines by low- and middle-income countries (where disease burdens are often the highest) has been slower than in high-income countries. In 2010, for example, only 13% of the total high-income country birth cohort lived in countries that did not have pneumococcal conjugate vaccines in their immunization schedules. Of the total low-income country birth cohort, 98% lived in countries that did not have pneumococcal conjugate vaccines in their schedules.

14. Coverage gaps persist between countries, as well as within countries. The average coverage with three doses of diphtheria-tetanus-pertussis-containing vaccine and with measles-containing vaccine in low-income countries was 16% and 15% below that of high-income countries in 2010, respectively. However, this represents a positive trend in comparison with the coverage gap of 30% for both vaccines in the year 2000.

15. In some countries, coverage of measles-containing vaccine in rural areas is 33% lower than in urban areas. Similarly, the measles vaccine coverage rate for the richest fifth of the population in some countries is up to 58% higher than for the poorest fifth. Coverage

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can also be very low in settlements of the urban poor, especially in cities with transitory migrant populations, and in indigenous communities.

16. Geographical distance from health centres is not the only determinant of low coverage; inequities are also associated with other socioeconomic determinants, such as income levels and the educational status of the mother. A special geographic focus is needed on lower-middle-income countries with large populations, where the majority of the unvaccinated live. Reaching underserved populations will be especially challenging, but inequities need to be tackled because these populations often carry a heavier disease burden and may lack access to medical care and basic services, with the fragile economies of individuals and their families suffering a severe disease-related impact as a consequence.

**New opportunities and challenges for the Decade of Vaccines (2011-2020)**

17. Individuals and communities, governments and health professionals have primary responsibility for exploiting the opportunities and confronting the challenges that this decade will bring. New and improved vaccines are expected to become available, based on a robust pipeline that includes several vaccines for diseases that are not currently preventable through vaccination. The introduction of new vaccines targeted against several important causes of major killer diseases, such as pneumonia, diarrhoea and cervical cancer can be used as a catalyst to scale up complementary interventions. In addition to reducing mortality, these new vaccines will prevent morbidity with resulting economic returns even in countries that have already succeeded in improving mortality rates. Innovations in existing vaccines will bring additional benefits, such as greater effectiveness, thermostability, easier administration and lower cost.

18. At the same time, the development of vaccines and other immunization innovations is facing increasingly complex manufacturing and regulatory processes, as well as rising research, development and production costs. As new vaccines (for example, against dengue and malaria) become available and underutilized vaccines (for example, those against cholera, human papillomavirus, rabies, rotavirus, rubella and typhoid) are administered more widely, supply and logistics systems - already burdened - will face an even greater need for innovations. Finally, the number of health workers, as well as their knowledge and skills, will need to be enhanced, better coordinated and better supervised. While the challenges are many, the introduction of new vaccines also represents an opportunity to strengthen immunization systems and to act as a catalyst to implement many of the required reforms. As national immunization investments increase, so must government oversight and accountability.

19. Immunization funding needs in the areas of research and development, procurement and delivery are expected to more than double in the coming decade. New and more complex vaccines will bring new funding requirements and countries will be confronted with difficult decisions in dealing with competing health priorities. Resources will need to be allocated more efficiently, with the relevant decisions guided by national priorities, capacity, clear information on the costs and benefits of choices, and improved financial management. Expenditures must be linked to outputs and impacts, showing a clear investment case for immunization.

20. As the economies of many low- and middle-income countries continue to grow, so will their potential to fund immunization. Countries that have relied on development assistance will be able to fund an increasing proportion of their immunization programmes, and may even, eventually, be able to fully sustain them. Some will be able to extend new financial and technical support to global immunization projects. At the same time, vaccine manufacturers in some of these countries will be expected to make an
even more significant contribution to the supply of high-quality, affordable vaccines, spreading the sources of production more widely and increasing competition.

21. The growing availability of information and penetration of mobile telephone and social networks can boost public demand for immunization, and ensure that people are made aware of both the benefits derived from vaccines and their potential risks. The immunization community can take advantage of social networks and electronic media to more effectively allay fears, increase awareness and build trust.

22. The lessons learnt from past decades, the unmet needs, and the opportunities and challenges that this decade presents have been carefully considered in the formulation of the guiding principles, measures of success and recommended actions that are articulated in the following sections.

SIX GUIDING PRINCIPLES

23. Six principles have guided the elaboration of the draft global vaccine action plan.

- **Country ownership:** countries have primary ownership and responsibility for establishing good governance and for providing effective and quality immunization services for all.

- **Shared responsibility and partnership:** immunization against vaccine-preventable diseases is an individual, community and governmental responsibility that transcends borders and sectors.

- **Equity:** equitable access to immunization is a core component of the right to health.

- **Integration:** strong immunization systems, as part of broader health systems and closely coordinated with other primary health care delivery programmes, are essential for achieving immunization goals.

- **Sustainability:** informed decisions and implementation strategies, appropriate levels of financial investment, and improved financial management and oversight are critical to ensuring the sustainability of immunization programmes.

- **Innovation:** the full potential of immunization can only be realized through learning, continuous improvement and innovation in research and development, as well as innovation and quality improvement across all aspects of immunization.

24. These six fundamental principles can realistically and effectively guide the full spectrum of immunization activities throughout the Decade of Vaccines (2011–2020). Although the draft global vaccine action plan will need to be translated into specific regional, country and community contexts, these guiding principles are universally applicable and relevant to each of the Decade of Vaccines’ goals and strategic objectives described below.

MEASURES OF SUCCESS

25. The Decade of Vaccines is about taking action to achieve ambitious goals. Early in the decade, this means achieving already established elimination and eradication goals. It means dealing with the public health emergency constituted by wild poliovirus transmission in order to secure a world free of poliomyelitis. It also means assuring the global or regional elimination of measles, rubella and neonatal tetanus. Completing this

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183 By 2015, achieve maternal and neonatal tetanus elimination (defined as less than one case of neonatal tetanus per 1000 live births) in every district, measles elimination in at least four WHO regions and rubella elimination in at least two WHO regions. By 2020, achieve measles and rubella elimination in at least five WHO regions.
agenda has never been more critical. Success will encourage the achievement of additional ambitious goals. Failure will mean that millions of preventable cases of disease and death will continue to occur.

26. Later in the decade, success will be recorded in terms of the expansion of immunization services to meet vaccination coverage targets in every region, country and community. In 2015, the coverage of target populations should reach the goal of the Global Immunization Vision and Strategy, 2006-2015 of at least 90% national vaccination coverage and at least 80% vaccination coverage in every district or equivalent administrative unit (the marker for this being coverage for diphtheria-tetanus-pertussis-containing vaccines). By 2020, coverage of target populations should reach these levels for all vaccines in national immunization programmes unless alternative targets exist. Vaccine introductions should also be monitored, with the goal of at least 80 low- or middle-income countries introducing one or more appropriate new or underutilized vaccines by 2015. These technical accomplishments will not be sustained unless countries take full ownership of their routine immunization programmes (see strategic objective 1 below).

27. During this decade millions of additional deaths and cases of disease should become preventable as a result of the development, licensure and introduction of new and improved vaccines and technologies for high-burden diseases. Specifically, progress towards the licensure and launch of vaccines should be tracked against one or more major pathogens not currently vaccine preventable (such as, cytomegalovirus, dengue virus, group A streptococcus, hepatitis C virus, hookworm, leishmania and respiratory syncytial virus) and at least one new platform delivery technology.

### Goals of the Decade of Vaccines (2011-2020)

- Achieve a world free of poliomyelitis
- Meet global and regional elimination targets
- Meet vaccination coverage targets in every region, country and community
- Develop and introduce new and improved vaccines and technologies
- Exceed the Millennium Development Goal 4 target for reducing child mortality

28. If these immunization-specific goals are achieved, hundreds of millions of cases and millions of future deaths will be averted by the end of the decade, billions of dollars of productivity will be gained, and immunization will contribute to exceeding the Millennium Development Goal 4 target for reducing child mortality (and the target that succeeds it post-2015). For example, it is estimated that if the coverage targets for introduction and/or sustained use of 10 vaccines alone (those against hepatitis B, *Haemophilus influenzae* type b, human papillomavirus, Japanese encephalitis, measles, meningococcus A, pneumococcus, rotavirus, rubella and yellow fever) in 94 countries during the decade are met, between 24 and 26 million future deaths could be averted compared with a hypothetical scenario under which these vaccines have zero coverage (see also paragraphs 89-99 below).

### Six strategic objectives

29. Continuous progress towards the following six strategic objectives will enable the achievement of the goals of the Decade of Vaccines (2011-2020).

i) **All countries commit to immunization as a priority.** Key indicators to monitor progress towards this strategic objective at the country level are the presence of a legal framework or legislation that guarantees financing for immunization and the presence of an independent technical advisory group that meets defined criteria.
ii) **Individuals and communities understand the value of vaccines and demand immunization as both their right and responsibility.** Progress towards increased understanding and demand can be evaluated by monitoring the level of public trust in immunization, measured by surveys on knowledge, attitudes, beliefs and practices.\(^{184}\)

iii) **The benefits of immunization are equitably extended to all people.** Progress towards greater equity can be evaluated by monitoring the percentage of districts with less than 80% coverage with three doses of diphtheria-tetanus-pertussis-containing vaccine and coverage gaps between lowest and highest wealth quintile (or another appropriate equity indicator).

iv) **Strong immunization systems are an integral part of a well-functioning health system.** The strength of health systems can be evaluated based on dropout rates between the first dose of diphtheria-tetanus-pertussis-containing vaccine and the first dose of measles-containing vaccine. The quality of data is important for monitoring the functioning of a health system. Data quality can be evaluated by monitoring whether immunization coverage data are assessed as high quality by WHO and UNICEF.

v) **Immunization programmes have sustainable access to predictable funding, quality supply and innovative technologies.** Key indicators to monitor progress towards this strategic objective will be the percentage of routine immunization costs financed through government budgets and globally installed capacity for production of universally recommended vaccines within five years of licensure/potential demand.

vi) **Country, regional and global research and development innovations maximize the benefits of immunization.** Key indicators of progress towards this strategic objective include proof of concept for a vaccine that shows greater or equal to 75% efficacy for HIV/AIDS, tuberculosis or malaria and the initiation of phase III trials for a first generation universal influenza vaccine. In addition, country research and development capacity can be measured by the institutional and technical capacity to manufacture vaccines and/or carry out related clinical trials and operational and organizational research.

30. Achieving the vision and goals of the Decade of Vaccines (2011-2020) will only be possible if all stakeholders involved in immunization commit themselves to, and take action to achieve, the six strategic objectives; uphold the Decade of Vaccines guiding principles when implementing all the actions; and regularly monitor and evaluate progress towards both strategic objectives and goals using the indicators described above (see also Annex 1).

31. An accountability framework is needed that defines the methodology and source of data for these indicators, identifies which stakeholders will be responsible for what actions, and articulates the process and responsibilities for monitoring and evaluating progress over the course of the Decade. The draft global vaccine action plan lays the groundwork for each of these elements. Further development and implementation of the accountability framework at country, regional and global levels could take place over the course of 2012 by leveraging the findings of the Commission on Information and Accountability for Women’s and Children’s Health and aligning work, wherever possible, with other accountability efforts and initiatives by all stakeholders at the country level to deliver and monitor progress.

**ACTIONS TO ACHIEVE STRATEGIC OBJECTIVES**

\(^{184}\) The Strategic Advisory Group of Experts working group on vaccine hesitancy will develop a definition of vaccine hesitancy and recommend specific questions from surveys (either existing or new) to fully formulate this indicator.
Strategic objective 1: all countries commit to immunization as a priority.

32. Committing to immunization as a priority first and foremost means recognizing the importance of immunization as a critical public health intervention and the value that immunization represents in terms of health and economic returns. Countries demonstrate a commitment to immunization by setting ambitious but attainable national targets and allocating adequate financial and human resources to programmes to achieve these targets; ensuring that their national immunization plans are fully integrated into national health plans, with appropriate budgets and formulated with the participation of all major stakeholders; and demonstrating good stewardship and implementation of their national health plans. Country commitment to immunization does not, however, imply that immunization programmes will be prioritized or funded at the expense of other vital health programmes.

33. National legislation, policies and resource allocation decisions should be informed by credible and current evidence regarding the direct and indirect impact of immunization. Much of the evidence base exists but does not reach policy-makers, as those who generate the evidence are not always those who interact with these decision-makers. Collaboration between, on the one hand, technical experts who generate the evidence and, on the other, the champions of immunization who construct context-specific messages that highlight the importance of immunization within health and social services, can unequivocally articulate the value of immunization and how immunization supports equity and economic development.

34. Independent bodies, such as regional or national immunization technical advisory groups, that can guide country policies and strategies based on local epidemiology and cost effectiveness should be established or strengthened, thus reducing dependency on external bodies for policy guidance. These bodies can readily be supported by institutions or individuals charged with collating and synthesizing information required for informed decision-making. Regional support systems and initiatives, such as the PAHO ProVac initiative, can be expanded to support countries in strengthening their decision-making. It is important that national immunization technical advisory groups or their regional equivalents, engage with academia, professional societies, and other national agencies and committees, such as the vaccine regulatory agencies, national health sector coordination committees, and interagency coordination committees, in order to ensure a cohesive and coordinated approach to achieving national health priorities. Strong links between ministries of health, education, and finance, as well as human resources and legislators are also essential for sustainable programme implementation.

35. Support and formal endorsement of national policies and plans at the highest political and administrative levels, nationally and subnationally, is considered essential for ensuring commitment and sustainability. Governments and elected officials are responsible for putting in place necessary legislation and budget allocations. As immunization is a strong indicator of the overall ability of the health system to deliver services, legislators should be encouraged to scrutinize, defend and closely follow immunization budgets, disbursements and immunization programme activities, both at the national level and within their respective constituencies. Civil society organizations can effectively advocate for greater commitment and hold governments accountable for commitments once they are made. Immunization programmes need to have management structures for programme implementation to be effective. Officials at the national and subnational levels responsible for implementation of the immunization plans can be held

185 ProVac is a package of tools to support: (i) the estimation of cost-effectiveness and epidemiological and economic impact of new vaccines; (ii) training; and (iii) the strengthening of national infrastructure for decision-making.

186 Especially important for delivering immunization to older children and adolescents through school health programmes and for monitoring school entry requirements with immunization.
accountable for programme performance when they are sufficiently empowered to provide effective leadership and have the required management and programme monitoring skills.

36. For high- and middle-income countries, commitment to immunization should cover the same areas, but may also include maintaining or assuming the role of development partners. Together with global agencies, development partner countries can coordinate the sharing of information and best practices among countries, help bridge temporary funding gaps, and support capacity strengthening by working with stakeholders in different country settings.

Table 2: Summary of recommended actions for strategic objective 1

<table>
<thead>
<tr>
<th>All countries commit to immunization as a priority.</th>
<th>Establish and sustain commitment to immunization.</th>
<th>Inform and engage opinion leaders on the value of immunization.</th>
<th>Strengthen national capacity to formulate evidence-based policies.</th>
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</thead>
<tbody>
<tr>
<td>• Ensure legislation or legal framework in all countries, including provisions for a budget line for immunization, and for monitoring and reporting.</td>
<td>• Develop comprehensive national immunization plans that are part of overall national health plans through a bottom-up process that includes all stakeholders.</td>
<td>• Explore models to promote collaboration between the stakeholders that generate evidence on immunization and those who use it in order to set priorities and formulate policies.</td>
<td>• Create, or strengthen existing, independent bodies that formulate national immunization policies (for example, national immunization technical advisory groups or regional technical advisory groups).</td>
</tr>
<tr>
<td>• Develop comprehensive national immunization plans that are part of overall national health plans through a bottom-up process that includes all stakeholders.</td>
<td>• Set ambitious but attainable country-specific targets within the context of morbidity and mortality reduction goals.</td>
<td>• Develop and disseminate the evidence base on the public health value of vaccines and immunization and the added value of achieving equity in access and use of immunization.</td>
<td>• Develop more effective ways for national regulatory agencies, health sector coordination committees, and interagency coordination committees to support immunization programmes as part of disease control.</td>
</tr>
<tr>
<td>• Scrutinize, defend and follow more closely immunization budgets, disbursements and immunization programme activities.</td>
<td>• Support local civil society organizations and professional associations to contribute to national discussions on immunization and health.</td>
<td>• Develop and disseminate the evidence base for the broad economic benefits of immunization for individuals, households, communities, and countries.</td>
<td>• Include immunization in the agendas of governing body meetings at all levels and in other social, health and economic forums.</td>
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programmes and preventive health care.
• Create regional forums and peer-to-peer exchange of information, best practices and tools.
• Create expanded and more transparent mechanisms for aggregating, sharing and using information to monitor commitments.

Strategic objective 2: individuals and communities understand the value of vaccines and demand immunization as both their right and responsibility.

37. Significant improvements in coverage and programme sustainability are possible if individuals and communities understand the benefits and risks of immunization; are encouraged to seek services; are empowered to make demands on the health system; and have ownership of the planning and implementation of programmes within their local communities. Although there has generally been a high demand for vaccination services, accessing hard-to-reach populations, attaining higher coverage levels and achieving equity objectives may require additional approaches to stimulate demand for vaccination.

38. Generating individual, household and community demand will require using traditional platforms more effectively as well as new strategies to convey the benefits of immunization, emphasize immunization as a core component of the right to health and encourage greater use of services. New efforts could take advantage of social media and approaches used by commercial and social marketing efforts to promote immunization and address concerns. New mobile and Internet technologies should also be utilized, drawing on the experiences and successes of other innovative public health campaigns. Communications and social research to identify the barriers to and drivers of vaccination should inform the development of context-specific messages. Lessons on vaccines and immunization should be included in the primary school education curriculum. Multisectoral approaches that promote efforts, such as female education and empowerment, will help improve utilization of immunization and health services in general.

39. Where appropriate, programme strategies could also include measures to provide an incentive both to households to seek immunization services and to health care providers to improve their performance in vaccinating children, particularly those that have not been reached previously. At the household level, conditional cash transfer programmes often include vaccination of children as a requirement for receiving household income transfers. There is evidence that such programmes may have a positive impact on immunization coverage rates, even in countries with high coverage rates, and particularly for more marginalized populations. Because conditional cash transfer programmes are often administered in countries as part of a broad package of social protection or poverty alleviation measures, these programmes provide an opportunity to link immunization programmes and health ministries with other broader development initiatives, including those administered by other ministries.

40. At the health facility level, both households and health care providers can be further motivated by in-kind gifts at the time of vaccination, or by giving performance-based financing bonuses to providers. There is some early evidence to suggest that performance-based financing of immunization services leads to increasing numbers of children being vaccinated, although more rigorous analysis of the impact of performance-based financing on immunization is still being carried out.

41. Providing incentives to health care workers and households through monetary and in-kind gifts has implementation challenges that need to be carefully addressed. These
schemes need to respect the autonomy of beneficiaries. Social research is also needed to determine the conditions under which incentives contribute to improved coverage and the types and levels of incentives that are appropriate for a given context. Demand-generation activities must be coupled with mechanisms to ensure reliability of vaccine supply.

42. Some reasons for hesitancy are undoubtedly amenable to improved communications and advocacy initiatives designed to counteract growing anti-vaccination lobby groups and to increase understanding of the value of vaccines or of the danger of diseases. However, others are best addressed by ensuring the quality of the services provided. Individuals will be less hesitant to use services if they perceive the quality of those services to be acceptable. They are more likely to come to vaccination sessions when scheduled services are convenient and predictably available; when practical counselling is offered about where and when to come for vaccination and why, and about what to expect following vaccination; when the health workers have a welcoming attitude; when waiting times are reasonable; and when services are offered without charge. Health care workers should receive training in effective communication to enable them to deal with the media and with local communities when there are reports of serious adverse events following immunization, in order to allay fears and tackle vaccine hesitancy.

43. Bringing about change will require the participation of individuals, households and communities in the development and implementation of all demand-generation strategies. It will also require new and stronger community-based advocates with local knowledge, credibility and the front-line experience necessary to drive change. The participation of in-country civil society organizations will be crucial to develop strong advocacy efforts and should be supported by capacity building. Here again, an effort that promotes collaboration between evidence generators and evidence users could provide training for champions and link with local social and professional networks, which are an important source of grass-roots immunization champions. This will especially be required as country programmes embrace a life-course approach to immunization.

44. Current advocates must recruit new voices - potentially including educators, religious leaders, traditional and social media personalities, family physicians, community health workers and immunization champions. Researchers and technical experts will also have an important role in creating greater community awareness and providing credible responses to misinformation regarding immunization.

45. Generating individual and community demand will reinforce country commitment to vaccines and immunization (strategic objective 1). Activities to generate demand for vaccines and immunization should build on the broader movement in order to help people to hold their governments accountable for access to health services.

Table 3: Summary of recommended actions for strategic objective 2

<table>
<thead>
<tr>
<th>Individual and communities understand the value of vaccines and demand immunization as both their right and responsibility.</th>
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<tbody>
<tr>
<td>Engage individuals and communities on the benefits of immunization and hear their concerns.</td>
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<tr>
<td>• Engage in a dialogue which both transmits information and responds to people's concerns and fears.</td>
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<tr>
<td>• Utilize social media tools and lessons learnt from commercial and social marketing efforts.</td>
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<tr>
<td>• Leverage new mobile and Internet-based technologies.</td>
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<tr>
<td>• Include immunization in the basic education</td>
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<tr>
<td>Curriculum.</td>
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<tr>
<td>Create incentives to stimulate demand.</td>
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<tr>
<td>Build advocacy capacity.</td>
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Strategic objective 3: the benefits of immunization are equitably extended to all people.

46. Today, four out of every five children receive at least a basic set of vaccinations during infancy and are therefore able to lead healthier, more productive lives. Unfortunately, this means one child in every five is not being reached. In this decade, the benefits of immunization should also be more equitably extended to all children, adolescents and adults. Achieving this strategic objective will mean that every eligible individual is immunized with all appropriate vaccines - irrespective of geographical location, age, gender, disability, educational level, socioeconomic level, ethnic group or work condition - thereby reaching underserved populations and reducing disparities in immunization both within and between countries. Because disease burdens tend to be disproportionately concentrated in more marginalized populations, reaching more people will not only achieve a greater degree of equity, but will also achieve a greater health impact and contribute to economic development. Furthermore, disease eradication and elimination goals cannot be met without achieving and sustaining high and equitable coverage.

47. In 2002, WHO, UNICEF and other partners introduced the concept of “Reaching Every District”, a first step toward achieving more equitable coverage. Through its various operational components, which include re-establishing outreach services, providing supportive supervision, engaging with communities, monitoring and use of data and
district planning and resource management, the Reaching Every District strategy was able to expand the provision of immunization services. Similarly, initiatives aimed at disease eradication and elimination or rapid mortality reduction have used strategies, such as national or subnational immunization days (for poliomyelitis eradication) and supplementary immunization activities (for measles and rubella elimination, measles mortality reduction and neonatal tetanus elimination). More recently, strategies collectively referred to as periodic intensification of routine immunization have been used to extend immunization to the unreached, packaged together with other primary health care interventions.

48. Even these strategies continue to miss populations, for example those that reside outside traditional social and governmental structures. To sustain the gains of these historical efforts and to achieve and sustain disease control goals, the Reaching Every District strategic approach should be recast as “Reaching Every Community”. To attain more equitable coverage, the definition of community should be expanded beyond geographically defined communities. Reaching every community will mean aiming to encompass every eligible individual, even those beyond typical government outreach.

49. Reaching every community will call for an understanding of the barriers to access and use of immunization; it will also require the underserved to be identified, and micro-plans at the district and community levels to be reviewed and revised in order to ensure that these barriers can be overcome. The rapid expansion of information technology should be leveraged to establish immunization registries and electronic databases that will allow each individual’s immunization status to be tracked, timely reminders to be sent when immunization is due and data to be accessed easily to inform actions. The introduction of unique identification numbers could be a catalyst for the establishment of such systems.

50. Drawing on the experiences of successful poliomyelitis vaccination campaigns, decentralized planning and outreach should be used to reach populations that are remote or nomadic or that have been historically marginalized. New strategies for reaching the urban poor and urban migrants will also be necessary. Given the tenuous and evolving community structures and the inadequate security involved, new approaches to community outreach will be especially critical for reaching these groups. This is all the more true in view of the fact that sometimes the most unifying force in these urban and peri-urban areas is a shared and deep-seated mistrust of outsiders, especially governments.

51. Implementing strategies to reach all underserved populations will require engagement with the nongovernmental sector, including civil society organizations and private sector organizations, and will need to involve all aspects of immunization including advocacy, social mobilization, service delivery and monitoring programme performance. To support such collaboration, governments should allocate increased resources to underserved communities and ensure that programmes have sufficient, well-trained personnel to execute strategies effectively. Partnerships across government sectors (for example, with educational institutions) and coordination with programmes that focus on vulnerable populations will be essential. In addition, efforts to provide high-quality immunization services to all children will need to continue unabated in order to protect gains already recorded.

52. There are other dimensions of equity that merit consideration during the Decade of Vaccines (2011–2020), including disparities between countries, adolescent and adult immunization, and immunization during emergencies.

53. Historically, it took decades before new vaccines used in high-income countries became available in low- and middle-income countries. Steps are being taken to address
this inequity, including the introduction of new vaccines, with the support of the GAVI Alliance. However, much more needs to be done to sustain and extend these gains, particularly to middle-income countries.

54. A “life-course” approach must also be taken in order to make the benefits of immunization available to all those at risk in every age group. As diseases are being successfully controlled through infant immunization, the need to boost immunity to sustain and extend these gains is increasingly being recognized. In addition, new and existing vaccines that are beneficial for school children, adolescents and adults at special risk - such as health workers, immunocompromised individuals, animal handlers, and the elderly - (for example, vaccines against human papillomavirus, influenza and rabies) are now available and being increasingly used. The success of efforts to eliminate maternal and neonatal tetanus and the benefits to both women and infants of influenza vaccination during pregnancy have increased interest in exploring the development of other vaccines that could be used during pregnancy (for example, group B streptococcus or respiratory syncytial virus vaccines). This will mean creating strategies for reaching individuals throughout their life course, and developing plans for the systems that will monitor and track progress.

55. Likewise, targeted plans are needed to ensure access to immunization during humanitarian crises, outbreaks and in conflict zones. These plans should include a focus on communication and provision for the development of vaccine stockpiles.

56. Social and operational research is needed to inform the design and test the effectiveness of the delivery strategies mentioned above. Key areas of focus for this research could include identifying the main causes of low coverage in particular areas and communities, assessing economic barriers to immunization, understanding the best approaches for reaching individuals of various ages, and assessing the most effective incentives for reaching different groups.

Table 4: Summary of recommended actions for strategic objective 3

<table>
<thead>
<tr>
<th>The benefits of immunization are equitably extended to all people.</th>
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<tbody>
<tr>
<td>Develop and implement new strategies to tackle inequities.</td>
</tr>
<tr>
<td>• Recast “Reaching Every District” to “Reaching Every Community” in order to deal with inequities within districts.</td>
</tr>
<tr>
<td>• Engage underserved and marginalized groups to develop locally tailored, targeted strategies for reducing inequities.</td>
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<tr>
<td>• Introduce appropriate new vaccines into national immunization programmes (see also objective 5).</td>
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<tr>
<td>• Establish a life-course approach to immunization planning and implementation, including new strategies to ensure equity across the life span.</td>
</tr>
<tr>
<td>• Prevent and respond to vaccine-preventable diseases during disease outbreaks and humanitarian crises, and in conflict zones.</td>
</tr>
<tr>
<td>Build knowledge base and capacity for enabling equitable delivery.</td>
</tr>
<tr>
<td>• Track each individual’s immunization status, leveraging immunization registries, electronic databases and national identification number systems.</td>
</tr>
<tr>
<td>• Take advantage of community structures to enhance communication and deliver services (for example,</td>
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</tbody>
</table>
Strategic objective 4: strong immunization systems are an integral part of a well-functioning health system.

57. The success of national immunization programmes in introducing new vaccines, attaining goals for quality, equity and coverage, and becoming financially sustainable depends upon a well-functioning health system. The many interconnected components of an immunization system require multi-disciplinary attention in order to build a cohesive, non-fragmented and well-functioning programme that coordinates and works in synergy with other primary health care programmes.

58. Health systems encompass a range of functions from policy and regulation to information and supply chain systems, human resources, overall programme management and financing. Health systems include both the public and private sectors, and in some countries the private sector can play a valuable role in educating households about the need for and benefits of vaccination, as well as providing health care. Some of these functions have been dealt with in other sections of this document. This section discusses the actions required to foster greater coordination between immunization and other programmes within health systems and to strengthen the information, human resources, supply chain and logistics components of health systems.

59. Immunization service delivery should continue to serve as a platform for providing other priority public health interventions, such as those for vitamin A supplementation, deworming, and insecticide-treated bednets. Other priority programmes should also serve as a platform for delivering immunization. Every contact with the health sector should be used as an opportunity to verify immunization status and provide immunization where indicated. Furthermore, as new vaccines become available that target some but not all pathogens that cause particular syndromes, such as pneumonia, diarrhoea and cervical cancer, it is important that their introduction be an opportunity to scale up the delivery of complementary interventions. For example, the vaccines against pneumococcus and rotavirus should be complemented with other actions to protect, prevent and treat related respiratory and diarrhoeal diseases.

60. New vaccine deployment should therefore be accompanied by comprehensive disease-control plans both within countries and globally. Coordination of immunization with other services should take place at all levels of a country’s programmes, involve outreach efforts and participation by health centres, and be a part of programme management.
Coordinating immunization with integrated primary health-care programmes may also facilitate social mobilization efforts, helping to generate community demand for services (strategic objective 2) and address inequity (strategic objective 3). Additionally, efforts should be made to ensure that global vaccine programmes focused on eradication and elimination goals (for example, poliomyelitis and measles campaigns) do not operate in silos. The choice of mechanisms to promote greater interaction and coordination between different programmes should be made by countries according to their local context. The synergies and efficiencies as a result of integration and coordination will be particularly beneficial in countries with fragile health systems.

61. Access to timely high-quality information is essential for effective immunization. Critical information includes process indicators that allow programmes to monitor their performance and take corrective action, and outcome indicators that measure the impact of programmes. Output and impact indicators need to be analysed along with expenditures in order to identify bottlenecks and best practices and to gauge overall programme efficiency (value for money). Immunization information systems need to be linked to broader health information systems, while remaining readily accessible and meeting immunization programme needs.

62. Monitoring of immunization coverage and dropout rates has been in place since the launch of the Expanded Programme on Immunization to ensure programme effectiveness. Although the quality and timeliness of data reporting have improved steadily over the years, the quality of administrative coverage data is still inadequate in many countries. Furthermore, the use of data in order to take corrective action at district and community levels is still unsatisfactory. New approaches to immunization tracking through unique identification numbers (discussed in strategic objective 3) can improve the quality of immunization coverage data and facilitate the development of comprehensive immunization registries. New technologies, including hand-held communication devices and mobile phones, can support this effort and facilitate data-sharing. Armed with higher-quality data and new data-analysis tools, programme managers at all administrative levels can use information to improve programme performance, allocate funding appropriately, and track progress more effectively.

63. Disease surveillance is critical for informing decision-making on the adoption of new vaccines and on the strategies for their use in their respective national programmes. Such surveillance is also essential for monitoring the impact of immunization and changes in disease epidemiology, and for supporting sustained use. Robust epidemiological data will also be crucial for understanding vaccine effectiveness and guiding priorities in the research and development community, and will help to identify the areas where research and development is most needed (strategic objective 6). Disease surveillance platforms need to be strengthened to improve the quality and sharing of information. This will include strengthening laboratory capacity for microbiological confirmation of diagnosis and for tracking the spread of diseases using molecular typing techniques.

64. On rare occasions, adverse reactions can affect the health of vaccine recipients. More frequently, coincidental health events can follow immunization and may be wrongly attributed to vaccines. In both instances, it is extremely important to detect and analyse promptly serious adverse events following immunization. To support low- and middle-income countries in managing such important issues, WHO and its partners have developed the Global Vaccine Safety Blueprint. This strategic plan will enable the countries concerned to have at least minimal capacity for vaccine safety activities; it will also enhance capacity for vaccine safety assessment in countries that introduce newly developed vaccines, that introduce vaccines in settings with novel characteristics or that both manufacture and use prequalified vaccines; and it will establish a global vaccine safety support structure. Implementing the Global Vaccine Safety Blueprint strategies to
build capacity for safety surveillance during the Decade of Vaccines (2011–2020) will ensure that everyone everywhere receives the safest vaccines possible and that safety concerns are not a cause of hesitancy in using vaccines.

65. The increasing complexity of immunization programmes and ambitious new goals, mean that more trained health workers are needed to manage the increased burden of work, including programme managers at the national and subnational levels as well as front-line workers who deliver services and interact directly with communities. Programme managers need to be equipped with technical knowledge about vaccines and immunization, as well as with management skills. Front-line health workers, who deliver not only vaccinations but also primary health care interventions and health education, need coordinated, comprehensive and very practical pre- and in-service training, with updated, relevant curricula and post-training supervision. Health-care workers need to be able not only to explain why immunization is important, but also to give advice to individuals and communities on nutrition, create a healthier environment and recognize the danger signs when someone falls ill. Immunization programmes should ensure that this training and supervision is effectively extended to community-based health workers. Civil society organizations can help with training and coordinating such workers.

66. Health workers can only be effective if sufficient supplies (vaccines, supplements and medicines) are available when they need them. The influx of new vaccines has outstripped the capacity of the current cold-chain system in many countries. Thus, supply chains and waste management systems urgently need to be expanded and made more efficient and reliable. They should be streamlined to maximize effectiveness. They should also take into account and make an effort to minimize the environmental impact of energy, materials and processes used for immunization both within countries and globally. The availability of new technologies provides the opportunity to innovate, not only to improve immunization supply chain management, but also to seek increased synergies with other sectors and supply systems for other health interventions. Another potential area of innovation concerns understanding the lessons learnt from private-sector practices and supply chain management. In addition, tasks that could be outsourced to private sector companies in order to create greater efficiency should be explored.

67. It will be essential to ensure that immunization supply systems are staffed with adequate numbers of competent, motivated and empowered personnel at all levels. Likewise, improvements to health information systems should also support the management of resources, helping staff to ensure that adequate quantities of vaccines are always available to meet demand. Efforts to strengthen supply chains should be implemented in such a way that they benefit both immunization programmes and broader national health efforts.

68. Developing stronger, more efficient, comprehensive approaches to disease control and immunization will require health ministries to take the lead in strengthening and coordinating immunization programmes and health systems more broadly, including engaging civil society organizations, academia and private practitioners. They can draw on the expertise of academics to help develop and deploy new tools and approaches to service delivery. Civil society organizations can contribute to the development of integrated programmes so that they are aligned with local realities and incorporate community-based human resources. Communities can ultimately hold their governments accountable by demanding integrated services. Regional and global organizations can also help by ensuring that data and best practices are shared in and across countries and that country programmes have access to analytical tools. Development partners can provide supplemental financial resources if needed.

Table 5: Summary of recommended actions for strategic objective 4
### Strong immunization systems that are an integral part of a well-functioning health system.

| Develop comprehensive and coordinated approaches. | • Ensure that global vaccine programmes focusing on eradication and elimination goals (for example, poliomyelitis and measles campaigns) are incorporated into national immunization programmes and do not operate independently.  
• Ensure that new vaccine deployment is accompanied by comprehensive plans to control targeted diseases.  
• Ensure coordination between the public and private sectors for new vaccine introduction, reporting of vaccine-preventable diseases and administration of vaccines, and ensure quality of vaccination in the public and private sectors.  
• Consider the inclusion of vaccines (as appropriate to national priorities) in health programmes across the life-course. |
| --- | --- |
| Strengthen monitoring and surveillance systems. | • Improve the quality of all administrative data concerning immunization and promote its analysis and use at all administrative levels to improve programme performance.  
• Develop and promote the use of new technologies for collection, transmission and analysis of immunization data.  
• Further strengthen and expand disease surveillance systems to generate information for decision-making, monitoring the impact of immunization on morbidity and mortality and changes in disease epidemiology.  
• Ensure capacity for vaccine safety activities, including capacity to collect and interpret safety data, with enhanced capacity in countries that introduce newly developed vaccines. |
| Strengthen capacity of managers and frontline workers. | • Ensure that immunization and other primary health-care programmes have adequate human resources to schedule and deliver predictable services of acceptable quality.  
• Increase levels of pre-service, in-service and post-service training for human resources, and develop new, relevant curricula that approach immunization as a component of comprehensive disease control.  
• Promote coordinated training and supervision of community-based health workers. |
| Strengthen infrastructure and logistics. | • Innovate to improve cold-chain capacity and logistics, as well as waste management.  
• Minimize the environmental impact of energy, materials and processes used in immunization supply systems, both within countries and globally.  
• Staff supply systems with adequate numbers of competent, motivated and empowered personnel at all levels.  
• Establish information systems that help staff to track the available supply accurately. |
Strategic objective 5: Immunization programmes have sustainable access to predictable funding, quality supply and innovative technologies.

69. To meet goals of the Decade of Vaccines (2011-2020), actions must be taken both within countries and globally to increase the total amount of available funding for immunization from both countries and development partners. Countries should ensure the financial sustainability of national immunization programmes through regular evaluation of resource needs; efficiency in service delivery; availability of adequate domestic financing; and resource mobilization from development partners to meet any funding gaps. Governments also need to explore alternative and innovative financing mechanisms for health and immunization. Some countries have established trust funds or use dedicated tax revenues, among other strategies. In addition, it is important to move beyond budgets and into expenditures. Governments can improve vaccine access and prevent shortages of vaccines, immunization equipment or health workers by assuring that budgeted funds are disbursed in an ongoing and timely fashion that responds to programmes’ needs.

70. Although the financing of immunization services is first and foremost a core responsibility of governments, development partners should support national strategies through more predictable, longer-term financing, and should also explore the next generation of innovative financing mechanisms. Emphasis needs to be placed on mutual accountability between countries and their development partners in terms of immunization financing. One possible approach is to undertake annual resource tracking of immunization financing from partners and governments alike. For both countries and development partners, evidence-based advocacy and policy efforts should be focused on obtaining a renewed commitment to past funding pledges.

71. There is also a need to improve the allocation, accountability and sustainability of funding. Coordinating funding support from development partners and other external sources to target national budget priorities will ensure that funds are addressing the most pressing country needs. Funding allocation strategies should be revised periodically to confirm they are achieving goals, such as eradication and elimination of disease, as quickly and as effectively as possible. Feedback loops should be established to enhance programme sustainability, results and impact. One potential methodology to explore is a pay-for-performance funding system. However, the merits of this approach must be balanced against the importance of ensuring the predictability of funding, the risks of creating perverse incentives, and the fact that implementation of such a scheme requires high-quality data. This would include linking international, national, and local funding distribution to specific performance metrics and leveraging the resulting metrics to promote programme improvement.

72. Innovative pricing and procurement mechanisms are needed to alleviate funding pressure and to support the development and scale-up of new and existing vaccines. Innovations will be particularly important for those lower-middle-income countries that do not have access to the PAHO, UNICEF and GAVI Alliance pricing and procurement mechanisms. Mechanisms to explore include differential pricing using new approaches to define price tiers and pooled negotiation or procurement methods for lower-middle-income countries. Current pooled procurement models exist in both the vaccines and pharmaceuticals markets. One example is the PAHO revolving fund pooled procurement and short-term credit mechanism. This and other models could be assessed and modified to best suit the needs of the lower-middle-income countries and the individual vaccine markets.

73. The provision of long-term sustainable funding will be an incentive to manufacturers, thereby improving supply security. In addition, supply-side interventions are needed. A
growing proportion of affordable vaccines that are used to immunize the world’s population are manufactured in middle- and lower-middle-income countries. In the coming decade, these countries will not only have a requirement to ensure the quality, safety and efficacy of vaccines used domestically, but also a growing global obligation to protect and enhance the security of the global immunization enterprise. Potential supply-side interventions to ensure quality, safety and efficacy include identifying and disseminating best practices in manufacturing and quality control, investing in research and development capabilities, and initiating technology transfers and co-development agreements.

74. A crucial but often overlooked key driver underpinning all these interventions is the quality assurance of vaccines. Good-quality assurance relies crucially on effective standardization, which ensures that each vaccine product can be manufactured consistently and also enables multiple manufacturers to make similar products of the same quality. Normative processes to achieve globally harmonized standards for vaccines already exist, including international biological reference materials, but action is needed to strengthen global standardization.

75. In addition, each country should develop the capacity to monitor and assure the safe use of vaccines, in line with the strategy defined in the WHO Global Vaccine Safety Blueprint initiative (as discussed under strategic objective 4). Action should also be taken to strengthen national regulatory systems and develop globally harmonized regulations in order to ensure that the increasing demand for regulatory reviews can be managed in an effective and timely manner. This is an issue not just for low- and middle-income countries involved in technology transfer, but also for regulatory agencies in high-income countries where expertise and resources need to be maintained. These supply-side interventions need to be based on solid business cases developed by countries to ensure the impact of these significant and long-term investments.

76. Making change happen with respect to sustainable funding will require commitments from governments and development partners to increase resources and improve programme efficiencies, as well as from additional countries joining the development partner ranks. Likewise, sustainable supply will require the multisectoral involvement of governments (for example, the science and technology, trade, industry and health sectors) in order to create an environment that helps suppliers to strengthen their capabilities. Emerging economies have a particularly important role to play in both cases, given their high rate of economic growth and the rapid expansion of the supply base there.

77. To increase alignment, activities currently performed by the UNICEF Supply Division and the GAVI Alliance to improve communication and coordination among countries, vaccine manufacturers and public-sector organizations should be further expanded. Countries need a forum where they can more clearly communicate expected demand for new vaccines and provide guidance on desired product profiles. This first-hand information would enable suppliers to make more informed product development and capacity planning decisions, thereby mitigating product development and supply risk. This information would also help development partners and other public-sector organizations to establish more defensible and reliable strategies and support plans. This forum could further be utilized to enable suppliers to accurately communicate the possible current and future range of pricing and supply to countries, and for countries to share information on and experience with vaccine procurement.

Table 6: Summary of recommended actions for strategic objective 5

| Immunization programmes have sustainable access to long-term funding and quality |
| **Increase total amount of funding.** | • Establish a commitment for governments to invest in immunization according to their ability to pay and the expected benefits.  
• Engage new potential domestic and development partners and diversify sources of funding.  
• Develop the next generation of innovative financing mechanisms. |
| **Increase affordability for middle-income countries.** | • Explore differential pricing approaches to define explicit criteria for price tiers and the current and future prices to be made available to lower middle-income and middle-income countries.  
• Explore pooled negotiation or procurement mechanisms for lower-middle-income and middle-income countries. |
| **Improve allocation of funding in low- and middle-income countries.** | • Strengthen budgeting and financial management in-country to better integrate financial and health care planning and priority setting.  
• Coordinate funding support from development partners and other external sources.  
• Evaluate and improve funding support mechanisms on the basis of their effectiveness in reaching disease goals.  
• Base funding on transparency and objectivity in order to ensure the sustainability of programmes.  
• Promote the use of cost and cost-benefit arguments in fund raising, decision-making, and in defence of immunization funding.  
• Explore pay-for-performance funding systems. |
| **Secure quality supply.** | • Build and support networks of regulators and suppliers to share best practices and to improve quality assurance capabilities and quality control.  
• Develop tools to strengthen global standardization of manufacturing and regulatory processes.  
• Strengthen national regulatory systems and develop globally harmonized regulations.  
• Provide a forum where countries can communicate expected demand for vaccines and technologies and provide guidance to manufacturers on desired product profiles. |

**Strategic objective 6: country, regional and global research and development innovations maximize the benefits of immunization.**

78. In the coming decade, targeted and innovative research and development efforts are needed across discovery, development and delivery. Innovative research and development efforts will lead to: (1) identification of mechanisms of protection and pathogenesis; (2) well-defined and novel antigenic targets for development of new vaccines; (3) development of bio-processing, formulation, manufacturing and delivery technologies for new and improved vaccines; and (4) development of disease-burden and cost-effectiveness data for in-country decision-making.
79. WHO has conducted a detailed study of disease prioritization and the Institute of Medicine in the United States of America is in the process of developing a model designed to assist decision-makers in prioritizing preventive vaccines based on health, economic, demographic, programmatic and social impact criteria, as well as scientific, technical and business opportunities. The Decade of Vaccines collaboration has not undertaken a vaccine or disease prioritization exercise. To complement the above efforts, a spectrum of research and development needs is presented across discovery, development and delivery, from which stakeholders can choose to invest according to their own priorities and perceptions of the return on their investments.

80. Across all research and development activities, increased engagement and consultation with end-users is needed to ensure that technologies and innovation are prioritized according to real demand and added value. New arrangements will also be required to facilitate the transfer of technologies and access to and sharing of associated information, while acknowledging and respecting intellectual property rights. In order to support this work and maximize its effectiveness of, scientists from disciplines not previously engaged in vaccine research (systems biology, nanotechnology, structural biology and metabolomics) will need to be recruited. Chemical and mechanical engineers, chemists and information technology specialists will also have key roles to play in this endeavour.

81. In addition, capacity building and human resource development are needed in low- and middle-income countries to conduct research and development, including finding better ways to conduct operational research and evaluate immunization programmes. Research and development is being conducted in institutions of excellence in many low- and middle-income countries. This capacity is producing indigenous data, as well as fostering bilateral and multilateral collaboration in basic sciences and vaccine development. Capacity can be further strengthened through peer-to-peer training and exchanges between countries. Greater networking among research centres (from discovery to clinical trials) will facilitate the exchange of ideas and the efficient building of partnerships among institutions in high-, middle- and low-income countries.

82. Discovery and basic research will lay the groundwork for impact in future decades. Research at the interface between host and pathogen is needed to enable the development of new vaccines. Advancing knowledge of innate and adaptive immune responses will permit more rational vaccine design. Strengthening the understanding of immunologic and molecular characteristics of microbes through systems biology will permit the identification of new antigenic targets for vaccine development and effective ways of predicting protective immune responses and mechanisms of protection. Appropriate studies of host genetics and biomarkers will contribute to understanding the causes of variation in human population responses to vaccines, or susceptibility to adverse effects.

83. For the development of new and improved vaccines and vaccine technologies, the research and development community will benefit from adopting best practices in portfolio and partnership management, including the identification of early indicators of success and failure to inform milestone-based investments. The community should also consider new approaches to ensure promising vaccine candidates are advanced from discovery to development, particularly where market incentives are insufficient. This is especially important for vaccines to prevent “neglected” diseases.

84. Research is needed to accelerate development, licensing and uptake of vaccines that are currently in early development, including development of technologies for more efficacious and less expensive manufacturing of vaccines. Greater access to the technology and associated information for adjuvants and their formulation into vaccines is
needed for advances in developing new and more effective vaccines. Non-syringe delivery mechanisms and vaccine packaging that best suit the needs and constraints of countries, as well as thermostable vaccines and new bioprocessing and manufacturing technologies, are priority research areas for accelerating the development of next-generation vaccines that are more effective, less expensive and easier to manufacture and deliver.

85. Additionally, the elaboration and aggressive pursuit of a global regulatory science agenda will improve manufacturing efficiency, better characterize products, improve clinical trial design and safeguard the highest standards for vaccine safety and efficacy. The challenge is considerable in achieving understanding of the adverse effects, finding ways to avoid them and yet not compromising the known efficacy of the existing product - and without incurring the costs of developing, testing and registering a new product. In this dimension, research on animal models and *in vitro* systems that better predict safety and efficacy would shorten the time for developing safe and effective vaccines and for making them available to communities. Knowledge of the correlates of protection and safety will greatly help to bring these second-generation products to licensure and use.

86. With respect to delivery, priority areas to improve programme efficiency and increase vaccine coverage and impact should include research on the use of effective information through modern communication technologies and social research in order to understand the cultural, economic and organizational determinants of immunization. Health economic analysis will guide the introduction and prioritization of vaccines, and hence representative epidemiological, immunological and operational studies and studies of vaccine impact will be needed.

87. Operational research on the most effective delivery approaches is also needed in order to overcome the challenges posed by life-course immunization (newborn, infant, adolescent, pregnant women, elderly, among others) and vaccination in emergency and outbreak situations. Research on immunological interference effects and optimization of delivery schedules will be required as more new vaccines are introduced into routine programmes and immunization is extended beyond the first year of life. In the case of special populations, such as pregnant women, confirmation of safety will be particularly important. Furthermore, research is required in order to develop biomarkers for validating immunization coverage estimates and enabling better measurement of population-level immunity profiles. In addition, research to develop field-usable and cost-effective diagnostic tools for establishing etiology that are suited for use at point-of-care in low-income countries will be valuable additions to improving surveillance quality.

88. Concerted action among the research community, manufacturers, health professionals, programme managers, national immunization technical advisory groups, vaccine regulatory agencies and development partners will be needed to attain the full potential of research and development in the next decade. Methods and arguments for prioritization and allocation of scarce resources will have to be agreed upon by these groups, balancing the tensions between country-driven choices and the need for large-scale research efforts and markets in order to sustain development and commercialization. Health professionals, programme managers, vaccine regulatory agencies and national immunization technical advisory groups can help to identify areas where innovations could be made, and assess their real demand and added value. Development partners can help promote a judicious allocation of some resources for research and development, according to the agreed priorities. The research community and manufacturers will have prime responsibility for promoting innovation and pursuing the research agenda defined above.

Table 7: Summary of recommended actions for strategic objective 6
Country, regional, and global research and development innovations maximize the benefits of immunization.

| Expand capabilities and increase engagement with end-users. | • Engage with end-users to prioritize vaccines and innovations according to perceived demand and added value.  
• Establish platforms for exchange of information on immunization research and consensus building.  
• Build more capacity and human resources in low- and middle-income countries to conduct research and development and operational research.  
• Increase networking among research centres for efficient building of partnerships among the institutions of high-, middle- and low-income countries.  
• Promote collaboration between traditional research disciplines and scientists from disciplines not previously engaged in vaccine research. |
| Enable the development of new vaccines. | • Research on the fundamentals of innate and adaptive immune responses, particularly in humans.  
• Research on immunological and molecular characteristics of microbes.  
• Improve understanding of the extent and causes of variation in pathogens and human population responses to vaccines. |
| Accelerate development, licensing and uptake of vaccines. | • Promote greater access to technology, expertise and intellectual property for adjuvants and their formulation into vaccines.  
• Develop non-syringe delivery mechanisms and vaccine packaging that best suit the needs and constraints of national programmes.  
• Develop thermostable rotavirus and measles vaccines.  
• Develop new bioprocessing and manufacturing technologies.  
• Develop a global, regulatory science research agenda.  
• Adopt best practices in portfolio and partnership management for research and development. |
| Improve programme efficiencies and increase coverage and impact. | • Research the use of more effective information through modern communication technologies.  
• Conduct representative epidemiological, immunological, social and operational studies and investigations of vaccine impact to guide health economics analysis.  
• Perform operational research on improved delivery approaches for life-course immunization, and vaccination in humanitarian emergencies, so-called fragile States and countries in and emerging from conflict.  
• Perform research on interference effects and optimum delivery schedules.  
• Perform research to develop improved diagnostic tools for conducting surveillance in low-income countries. |
HEALTH RETURNS ON INVESTMENT IN IMMUNIZATION

89. The draft global vaccine action plan has outlined a set of ambitious goals and strategic objectives for the decade to broaden the impact and reach of immunization across the globe. By extending coverage for existing vaccines, introducing new vaccines and pursuing elimination and eradication for specific diseases, millions of deaths can be averted and billions of dollars in economic benefit can be generated.

90. It is projected that costs to sustain and scale up current immunization programmes, introduce new and underutilized vaccines, and conduct supplemental immunization activities to reach elimination and eradication goals in the world’s 94 low- and lower-middle-income countries will rise from between US$ 3500 million and US$ 4500 million in 2011 to between US$ 6000 million and US$ 8000 million in 2020, costing approximately between US$ 50 000 million and US$ 60 000 million cumulatively over the course of the decade (from 2011 to 2020). The following estimates all pertain to these 94 countries.  

91. An estimated US$ 42 000 million to US$ 51 000 million of these costs (roughly 85% of the total) will support expanding routine immunization coverage and introducing additional vaccines to routine immunization programmes. For example, pneumococcal vaccine coverage for the birth cohort in the 94 countries is projected to go from 8% in 2011 to approximately 90% by 2020. Similarly, coverage with the pentavalent vaccine (against diphtheria-tetanus-pertussis hepatitis B and Hib) is projected to move from 50% in 2011 to more than 90% by 2020. To take another example, it is anticipated that up to five additional vaccines that are currently not licensed or widely used in low- and lower-middle-income countries will be introduced across many of the countries in the analysis during the decade: vaccines against cholera, dengue and malaria, inactivated poliovirus vaccine, and typhoid Vi conjugate vaccine. Delivery programmes will need to be strengthened to ensure they meet current needs, are well-maintained over the decade, have sufficient capacity to accommodate additional vaccines that are planned to be introduced, and facilitate immunization coverage aspirations across low- and lower-middle-income countries. As a consequence, the costs of annual routine immunization will increase from approximately US$ 2500 million in 2011 to US$ 7500 million by 2020.

92. Of these costs, an estimated cumulative figure of between US$ 8000 million and US$ 9000 million (the remaining 15% of the total) will be for supplementary immunization activities for accelerated disease control and eradication and elimination efforts throughout the decade, which will complement routine immunization programmes. This analysis assumes that these efforts will be focused on measles, meningococcus A meningitis, poliomyelitis, rubella, tetanus and yellow fever.

93. The costs described above for routine and supplementary immunization activities encompass the projected costs of the acquisition of vaccines and injection supplies, as well as the delivery of those vaccines and supplies, including transportation and cold chain logistics, human resources, training, social mobilization, surveillance and programme management. These costs do not include the additional costs or efficiencies that may be generated through the actions recommended in the draft global vaccine action plan where

187 Countries included in the scope of the costing analysis include 92 low- and lower-middle-income countries according to the July 2011 World Bank Classification (available at http://www.icsoffice.org/Documents/ DocumentsDownload.aspx?DocumentId=474, accessed 11 April 2012) in addition to two upper-middle-income countries (Azerbaijan and Cuba) which receive GAVI Alliance support for existing vaccines, but which have graduated from support for future vaccines.

188 Diseases covered by the vaccines included in the scope of the costing analysis include: diphtheria-tetanus-pertussis, hepatitis B, Haemophilus influenzae type b, human papillomavirus, Japanese encephalitis, measles, meningococcus A, mumps, pneumococcus, poliomyelitis, rotavirus, rubella, tuberculosis and yellow fever.
there is an insufficient evidence base for these costs at this time. Specifically, it does not include the additional cost of scaling up seasonal influenza vaccination or the additional resource needs for increased surveillance, increased civil society engagement, and current and additional technical agency support to implement the draft global vaccine action plan. Nevertheless, the costs do represent the majority of the cost of achieving the strategic objectives of the Decade of Vaccines (2011-2020).

94. The governments of low- and lower-middle-income countries will continue to play a pivotal role in meeting resource needs. Assuming that country funding for immunization grows in line with projected gross domestic product and all GAVI Alliance-eligible countries fully meet its co-financing requirements, it is estimated that the available funding from country governments for routine immunization and supplemental immunization activities could total approximately US$ 20 000 million over the decade. In addition, if the GAVI Alliance renews its current level of funding for the 2016–2020 period, its resources will generate an estimated additional US$ 12 000 million for funds for the decade, approximately US$ 11 000 million for routine immunization programmes and approximately US$ 1000 million for programmes involving supplementary immunization activities. Based on these assumptions, country governments and the GAVI Alliance combined could provide a total of approximately US$ 32 000 million in funding for the decade because they do not include contributions from development partners beyond that provided through the GAVI Alliance (owing to the considerable uncertainty surrounding future levels of development partner financing).

95. Meeting the estimated US$ 18 000 million to US$ 28 000 million in additional funding will require commitment from all stakeholders, with governments needing to continue making immunization a priority in resource allocation decisions; development partners needing to sustain and bolster access to funding for immunization in spite of competing priorities; and the entire community needing to continue efforts to reduce the cost of vaccine acquisition and immunization service delivery.

96. All stakeholders investing together will drive a significant health and economic impact. Work to sustain or extend coverage of existing vaccines and efforts to introduce new vaccines, if undertaken together, have the potential to avert millions of future deaths, as well as hundreds of millions of cases of disease, and generate billions of dollars in economic impact over the decade.

97. As an example of the potential impact of immunization, a sub-analysis of 10 vaccines, delivered during the decade, that represent an estimated US$ 42 000 million of the US$ 50 000 million to US$ 60 000 million cost for the decade, have the potential to avert in total between 24 and 26 million future deaths (Table 8) as compared with a hypothetical scenario under which these vaccines have zero coverage.

Table 8: Total future deaths averted, 2011-2020, assuming no vaccination as the counterfactual

<table>
<thead>
<tr>
<th>Group</th>
<th>Vaccine</th>
<th>No. of future deaths averted&lt;sup&gt;a,b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Expanded</td>
<td>Measles 1st dose</td>
<td>10.6M</td>
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</table>

<sup>189</sup> Vaccines included in health benefits analysis cover the following diseases in countries representing 99.5% of the birth cohort of the 94 countries included in the costing analysis: hepatitis B, Haemophilus influenzae type b, human papillomavirus, Japanese encephalitis, meningitis A, pneumococcus, rotavirus, rubella, yellow fever and measles.

<sup>190</sup> Data were insufficient to estimate morbidity averted through immunization in these countries.
<table>
<thead>
<tr>
<th>Programme on Immunization vaccine&lt;sup&gt;c&lt;/sup&gt;</th>
<th>Measles 2nd dose</th>
<th>Measles supplementary immunization activities</th>
<th>0.4M</th>
</tr>
</thead>
<tbody>
<tr>
<td>New or underutilized vaccines</td>
<td>Hepatitis B&lt;sup&gt;d&lt;/sup&gt;</td>
<td></td>
<td>5.3-6.0M</td>
</tr>
<tr>
<td></td>
<td><em>Haemophilus influenzae</em> type b</td>
<td></td>
<td>1.4-1.7M</td>
</tr>
<tr>
<td></td>
<td>Pneumococcus</td>
<td></td>
<td>1.6-1.8M</td>
</tr>
<tr>
<td></td>
<td>Rotavirus</td>
<td></td>
<td>0.8-0.9M</td>
</tr>
<tr>
<td></td>
<td>Human papillomavirus</td>
<td></td>
<td>0.5M</td>
</tr>
<tr>
<td></td>
<td>Yellow fever&lt;sup&gt;e&lt;/sup&gt;</td>
<td></td>
<td>0.03-0.04M</td>
</tr>
<tr>
<td></td>
<td><em>Meningococcal A meningitis</em>&lt;sup&gt;f&lt;/sup&gt;</td>
<td></td>
<td>0.03M</td>
</tr>
<tr>
<td></td>
<td>Japanese encephalitis&lt;sup&gt;g&lt;/sup&gt;</td>
<td></td>
<td>0.07M</td>
</tr>
<tr>
<td></td>
<td>Rubella</td>
<td></td>
<td>0.4M</td>
</tr>
<tr>
<td><strong>Total (2011-2020)</strong></td>
<td></td>
<td></td>
<td><strong>24.6-25.8M</strong></td>
</tr>
</tbody>
</table>

<sup>a</sup> The estimated figure for future deaths averted was developed by a working group that included staff from WHO, the GAVI Alliance, the Bill & Melinda Gates Foundation and PATH. The estimate uses a mix of static and dynamic cohort models and various data sources across the 10 vaccines, including the Lives Saved Tool. Vaccine coverage projections are from the GAVI Strategic Demand Forecast 4.0 (4 October 2011) and from the GAVI Adjusted Demand Forecast.

<sup>b</sup> Ranges shown for estimates where alternative assumptions were considered for the scope of countries and the demand forecast.

<sup>c</sup> Data were insufficient to allow estimation of deaths averted from BCG, diphtheria, tetanus or pertussis vaccines.

<sup>d</sup> Scaled up in the decade 2001 to 2010.

<sup>e</sup> Disease burden limited to only a few regions.

<sup>f</sup> Same as above.

<sup>g</sup> Same as above.

98. The figures for future deaths averted represent the full estimated benefits that can be achieved during the decade for these 10 vaccines, through sustaining or enhancing current immunization levels and introducing additional vaccines into the national immunization programmes of the selected countries, using no vaccination as the counterfactual. They are not limited to only the incremental benefits of the additional actions undertaken during the Decade of Vaccines (2011-2020).

99. The current projections of costs, available funding and health impact will evolve as additional analysis is completed and new and better data become available. Additional analysis will allow for the expansion of the scope described by this document, including increasing the number of diseases covered by the cost and health benefits analysis, quantifying impact on morbidity, quantifying economic benefits and further increasing the level of detail of costing and funding projections. Additional analysis is needed in order to better understand vaccine research and development costs and benefits, which are not included in the current projections. New and better data will, among other things, enhance the analysis with revised disease burden statistics, better vaccine price forecasts, improved population information and more consistent data across all countries. In addition, a process should be developed and maintained to allow for updates to cost, funding, and health and economic impact estimates at the country and global levels, ideally on an annual basis. This will facilitate enhanced planning, coordination and engagement among the many stakeholders that will be required to achieve the strategic objectives and goals of the Decade of Vaccines (2011-2020).
CONTINUING MOMENTUM FOR THE DECADE OF VACCINES (2011-2020)

100. Ensuring success throughout the Decade of Vaccines requires additional focus and action beyond the development of the draft global vaccine action plan. Four critical sets of activities will be required in order to translate the action plan into actions and results: development of tools for translation of the plan; development of a complete accountability framework; securing commitments from the stakeholder community; and communicating Decade of Vaccines opportunities and challenges.

101. Tools are needed that provide the full thinking behind the draft global vaccine action plan, together with details, in order to enable implementation. The production, publication and communication of these tools will help stakeholders better understand how to translate the actions recommended in the action plan into the local context.

102. The draft global vaccine action plan lays the groundwork for an accountability framework, which will be finalized with more detailed roles and responsibilities for stakeholders, a complete set of indicators, the methodology and data sources for each indicator detailed and baselines established where required. Investments are needed to improve data quality and develop more robust in-country monitoring and evaluation systems. Regular audits should be conducted to verify data quality. Progress should be reviewed annually, beginning in 2013, by country, the WHO regional committees and the Health Assembly.

103. Commitments aligned to the draft global vaccine action plan from countries, civil society organizations, multilateral agencies, development partners and vaccine manufacturers can transform the action plan from a document to a movement. Efforts to build these commitments and a strategy for coordinating them will be required at the global, regional and country levels. Appropriate channels must be identified and targeted communications developed to ensure that Decade of Vaccines messages reach and resonate with all stakeholders.

104. The period of time immediately following the Sixty-fifth World Health Assembly will be critical for ensuring that the agenda-setting translates into effective action. Key opportunities to sustain and build on the current momentum during the remainder of 2012 include the WHO regional committee meetings, the meeting of the Board of the GAVI Alliance, the UNICEF Executive Board meeting, the GAVI Alliance Partners’ Forum and the Child Survival: A Call to Action summit.

105. The Decade of Vaccines collaboration is a time-limited effort that ends with the completion of the draft global vaccine action plan and related activities identified above. There will be no new structure to support the implementation phase of the Decade of Vaccines/global vaccine action plan. Lead stakeholders need to assume ownership to support implementation and progress monitoring.

106. WHO will play a leadership role for the action plan as the normative lead agency in global health, including the defining of norms and standards for production and quality control of vaccines, as well for strengthening immunization delivery, programme monitoring and surveillance systems. In collaboration with other stakeholders, the WHO Secretariat will also advocate for and provide technical support to Member States in promoting greater country ownership, creating synergies between immunization and other primary health-care programmes and implementing research, notably to increase programme efficiencies and impact.

ACTION BY THE HEALTH ASSEMBLY
107. The Health Assembly is invited to adopt the resolution on World Immunization Week recommended by the Executive Board in resolution EB130.R12.

108. It is further invited to consider the following draft resolution:

The Sixty-fifth World Health Assembly,

Having considered the report on the draft global vaccine action plan;

Recognizing the importance of immunization as one of the most cost-effective interventions in public health which should be recognized as a core component of the human right to health;

Acknowledging the remarkable progress made in immunization in several countries to ensure that every eligible individual is immunized with all appropriate vaccines, irrespective of geographic location, age, gender, disability, educational level, socioeconomic level, ethnic group or work condition;

Applauding the contribution of successful immunization programmes in achieving global health goals, in particular in reducing childhood mortality and morbidity, and their potential for reducing mortality and morbidity across the life-course;

Noting that the introduction of new vaccines targeted against several important causes of major killer diseases such as pneumonia, diarrhoea and cervical cancer can be used as a catalyst to scale up complementary interventions and create synergies between primary health care programmes; and that beyond the mortality gains, these new vaccines will prevent morbidity with resulting economic returns even in countries that have already succeeded in reducing mortality;

Concerned that, despite the progress already made, disease eradication and elimination goals such as the eradication of poliomyelitis, the elimination of measles, rubella, and maternal and neonatal tetanus cannot be met without achieving and sustaining high and equitable coverage;

Concerned that low- and middle-income countries where the adoption of available vaccines has been slower may not have the opportunity to access newer and improved vaccines expected to become available during this decade;

Alarmed that globally routine immunization services are not reaching one child in five, and that substantial gaps persist in routine immunization coverage within countries;

Recalling resolutions WHA58.15 and WHA61.15 on the global immunization strategy,

1. ENDORSES the Global Vaccine Action Plan;

2. URGES Members States:

   (1) to apply the vision and the strategies of the Global Vaccine Action Plan to develop the vaccines and immunization components of their national health strategy and plans, according to the epidemiological situation in their respective countries;

   (2) to commit themselves to allocating adequate human and financial resources to achieve the immunization goals and other relevant key milestones;
(3) to report every year to the regional committees during a dedicated Decade of Vaccines session, on lessons learnt, progress made, remaining challenges and updated actions to reach the national immunization targets;

3. REQUESTS the Director-General:

(1) to foster alignment and coordination of global immunization efforts by all stakeholders in support of the implementation of the Global Vaccine Action Plan;

(2) to identify human and financial resources for the provision of technical support in order to implement the national plans of the Global Vaccine Action Plan and monitor their impact;

(3) to monitor progress and report annually, through the Executive Board, to the Health Assembly, until the Seventy-first World Health Assembly, on progress towards achievement of global immunization targets, as a substantive agenda item, utilizing the proposed accountability framework to guide discussions and future actions.

ANNEX 1

SUMMARY OF RECOMMENDED INDICATORS

Goal-level indicators

<table>
<thead>
<tr>
<th>Goal</th>
<th>By 2015</th>
<th>By 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve a world free of poliomyelitis</td>
<td>• Interrupt wild poliovirus transmission globally</td>
<td>• Certification of poliomyelitis eradication</td>
</tr>
<tr>
<td>Meet global and regional elimination targets</td>
<td>• Neonatal tetanus eliminated in all WHO regions</td>
<td>• Measles and rubella eliminated in at least five WHO regions</td>
</tr>
<tr>
<td></td>
<td>• Measles eliminated in at least four WHO regions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Rubella/congenital rubella syndrome eliminated in at least two WHO regions</td>
<td></td>
</tr>
<tr>
<td>Meet vaccination coverage targets in every region, country and community</td>
<td>• At least 80 low- and middle-income countries have introduced one or more new or underutilized vaccines</td>
<td>• Reach 90% national coverage and 80% in every district or equivalent administrative unit for diphtheria-tetanus-pertussis-containing vaccines</td>
</tr>
<tr>
<td></td>
<td>• Reach 90% national coverage and 80% in every district or equivalent administrative unit for all vaccines in national programmes, unless otherwise recommended</td>
<td></td>
</tr>
<tr>
<td>Develop and introduce new and improved vaccines and technologies</td>
<td></td>
<td>• Licensure and launch of vaccine or vaccines against one or more major diseases for which a vaccine does not currently</td>
</tr>
</tbody>
</table>
exist (such as dengue, hepatitis C, cytomegalovirus, respiratory syncytial virus, leishmaniasis, hookworm and group A streptococcus)

- Licensure and launch of at least one platform delivery technology

| Exceed the Millennium Development Goal 4 target for reducing child mortality | Reduce under five mortality rate by two thirds (compared to 1990) | Exceed the Millennium Development Goal 4 target for reducing child mortality. |

Strategic objective level indicators

<table>
<thead>
<tr>
<th>Strategic objective</th>
<th>Indicators</th>
</tr>
</thead>
</table>
| All countries commit to immunization as a priority               | • Presence of a legal framework or legislation that guarantees immunization financing  
• Presence of an independent technical advisory group that meets defined criteria                                                                 |
| Individuals and communities understand the value of vaccines and demand immunization both as a right and a responsibility | • Level of public trust in immunization, measured by surveys on knowledge, attitudes, beliefs and practices |
| The benefits of immunization are equitably extended to all people | • Percentage of districts with less than 80% coverage with 3 doses of diphtheria-tetanus-pertussis-containing vaccine  
• Reduction in coverage gaps between lowest and highest wealth quintile (or another appropriate equity indicator) |
| Strong immunization systems are an integral part of a well functioning health system | • Dropout rate between first dose of diphtheria-tetanus-pertussis-containing vaccine and first dose of measles-containing vaccine  
• Immunization coverage data assessed as high quality by WHO and UNICEF |
| Immunization programmes have sustainable access to predictable funding, quality supply and innovative technologies | • Percentage of routine immunization costs financed through government budgets  
• Installed capacity for production of universally recommended vaccines within five years of licensure/potential demand |
| Country, regional and global research and development innovations maximize the benefits of | • Proof of concept for a vaccine that shows greater than or equal to 75% efficacy for HIV/AIDS, tuberculosis, or malaria  
• Phase III clinical trials of a first generation universal |

\[191\] The working group on vaccine hesitancy of WHO’s Strategic Advisory Group of Experts on immunization will develop a definition of vaccine hesitancy and recommend specific questions from surveys (either existing or new) to fully formulate this indicator.
ANNEX 2

STAKEHOLDER RESPONSIBILITIES

There is an opportunity to achieve real progress in the next decade. Realization of this potential is contingent upon all stakeholders having clearly defined and coordinated responsibilities. Primary responsibility is held by individuals and communities, governments and health professionals, as recipients and providers of immunization respectively. Other stakeholders also have an important role in achieving the objectives.

Individuals and communities, as recipients of immunization, should do the following:
- Understand the risk and benefits of vaccines and immunization, viewing this as part of being a responsible citizen.
- Demand safe and effective immunization programmes as a right from their leaders and government, and hold leaders and government accountable for providing them.
- Participate in public-health discussions and be involved in key decisions about immunization processes.
- Participate and contribute to the immunization delivery process and convey the needs and perspectives of their communities to the policy-makers.

Governments, as the main providers of immunization, should do the following:
- Increase support for national immunization programmes and ensure financial sustainability by 2020.
- Depending upon countries’ income and as economies grow, fund an increasing proportion of domestic immunization programmes, progressing to the full funding of domestic programmes, and then funding global immunization efforts.
- Develop and introduce laws, regulations, and policies that support immunization programmes and a secure, high-quality supply base, if necessary.
- Develop region- and country-specific plans, together with other stakeholders in region/country.
- Prioritize and assume full ownership of national immunization programmes in order to create equity-driven programmes that reach every community.
- Work with stakeholders within and outside governments.
- Respond with timely information when public concerns are raised about safety and efficacy to sustain public trust.
- Ensure immunization programmes are adequately staffed with personnel who are well trained and given appropriate incentives to manage the programme and deliver services.
- Increase awareness of the importance of immunization to improve a population’s health and its contributions to strengthening health systems and primary health care.
- Effectively convey messages on vaccines to create demand.
• Engage in dialogue with communities and media and use effective communications techniques to convey messages about vaccines and to address safety concerns.
• Encourage and support research on vaccines and vaccination issues; and encourage education at all levels on vaccines.
• Collaborate regionally and internationally in advocacy programmes, evidence sharing, and coordinated preparedness.
• Participate in open dialogues with manufacturers to ensure affordability of current and new vaccines.

**Health professionals** should do the following:
• Provide high-quality immunization services and information on them.
• Introduce vaccine educational courses on immunization at universities and institutions training health-care professionals as well as continuing education for all health-care providers (medical, nursing, pharmacy and public health practitioners).
• Identify areas where immunization services could be improved and innovations made.
• Serve as proactive, credible voices for the value of vaccines and recruit other advocacy voices.
• Use existing and emerging technologies to improve delivery and better capture information.
• Engage in dialogue with communities and the media and use effective communications techniques to convey messages about vaccines and to address safety concerns.

**Academia** should do the following:
• Promote innovation to accelerate the development of new and improved vaccines, contribute to the optimization of vaccine formulation and immunization programme logistics, and lay the groundwork for the impact of immunization in future decades.
• Pursue a multidisciplinary research agenda that focuses on transformational impact and is based on the needs of end users.
• Develop vaccines and technologies that will optimize and maximize vaccine delivery.
• Embrace new ways of working that speed up scientific progress.
• Improve dialogue with other researchers, regulators and manufacturers in order to align actions and increase effectiveness in responding to local and global immunization challenges.
• Provide the core data, methods and arguments that help drive the continued prioritization of immunization both globally and locally.
• Engage more with systematic reviews to identify areas where solid scientific evidence exists (which should be the basis of health policies) and those areas where such evidence is lacking (which would be the basis for future primary research).
• Provide evidence and outline best immunization practices.
• Support the development of manufacturing capabilities.
• Promote budget allocation for vaccine and immunization research.

**Manufacturers** should do the following:
• Continue to develop, produce and supply innovative and high-quality vaccines that meet countries’ needs.
• Support research and an education agenda for immunization.
• Participate in open dialogues with countries and the public sector to ensure sustainable access to current and new vaccines.
• Continue to innovate manufacturing processes and pricing structures.
• Support the media outreach for the Expanded Programme on Immunization to increase awareness.
• Support rapid scale-up and adoption as new or improved vaccines emerge.
• Develop partnerships that support the growth of manufacturing capabilities and increase vaccine supply and innovation.
• Work in coordination with other partners on vaccine and immunization advocacy.

**Global agencies**, such as WHO, UNICEF, the World Bank, regional development banks and the GAVI Alliance, should do the following:

• Advocate for and provide technical support to promote country ownership.
• Strengthen national capabilities and regional infrastructure.
• Continue to define norms and guidelines to improve vaccine and immunization services, striving to achieve greater equity and sensitivity to gender and subpopulation (including, among others, minorities and age groups).
• Promote synergies between immunization and other health services as well with other sectors such as, education, economic development and financing.
• Fund the provision of vaccines and immunization-related activities.
• Work with all stakeholders to improve technical support to strengthen immunization and other components of health systems.
• Encourage, share and support evidence-based decision-making across the spectrum of development, health and immunization stakeholders.
• Engage partners to generate popular demand for immunization and support programme research and improvements.
• Promote the idea of sustainable national funding and engage rapidly emerging economies as funding partners.
• Develop mechanisms for mutual accountability that hold all governments, programmes and development partners responsible for committed levels of support.
• Promote a dialogue between manufacturers and countries to align supply and demand.
• Pursue innovative financing and procurement mechanisms that reinforce country ownership, and promote equity and affordability for low- and middle-income countries.

**Development partners**, such as bilateral agencies, foundations and philanthropists, should do the following:

• Fulfil institutional mandates and missions in the health field.
• Support countries and regional entities to achieve national and regional goals, and contribute to the advancement of their priorities.
• Promote country ownership and country-led health, vaccine and immunization plans that include budgets for improving access to services and reducing the equity gap in coverage.
• Promote comprehensive, integrated packages of essential interventions and services that include vaccines and immunization and strengthen health systems.

• Provide predictable long-term funding aligned with national plans and encourage new and existing partners to fund vaccines and immunization.

• Build civil society capacity and support civil society organization activities in countries.

• Participate in international advocacy through access to open evidence that can be shared.

• Maintain transparent and coordinated funding, accompanied by performance-based evaluation.

Civil society, including nongovernmental organizations and professional societies, should do the following:

• Get involved in the promotion and implementation of immunization programmes at both country and global level.

• Participate in the development and testing of innovative approaches to deliver immunization services that reach the most vulnerable people.

• Follow national guidelines and regulations in the design and delivery of immunization programmes that fulfil the duty of accountability to national authorities.

• Educate, empower and engage vulnerable groups and communities on their right to health, including vaccines and immunization.

• Build grass-roots initiatives within communities to track progress and hold governments, development partners and other stakeholders accountable for providing high-quality immunization services.

• Contribute to improved evaluation and monitoring systems within countries.

• Engage in country, regional and global advocacy beyond the immunization community to ensure vaccines and immunization are understood as a right for all.

• Collaborate within and across countries to share strategies and build momentum for improved health, vaccines and immunization.

Media should do the following:

• Understand the benefits of, and concerns about, immunization in order to accurately report on and effectively promote immunization programmes.

• Engage in country, regional and global advocacy beyond the immunization community to ensure vaccines and immunization are understood as a right for all.

• Use effective communications techniques to convey messages about vaccines and to address safety concerns.

The private sector should do the following:

• Support the diversification of funding sources for immunization programmes (among others, private sector, insurance providers and patients).

• Engage in country, regional and global advocacy beyond the immunization community and serve as champions for immunization to ensure vaccines and immunization are understood as a right for all.
RESOLUTION 13.12: Draft global vaccine action plan

Executive Board Resolution EB130.R12

World Immunization Week

The Executive Board, having considered the report on the draft global vaccine action plan, \(^{192}\) RECOMMENDS to the Sixty-fifth World Health Assembly the adoption of the following resolution:

The Sixty-fifth World Health Assembly,

Having considered the report on the draft global vaccine action plan;

Recalling resolutions WHA58.15 and WHA61.15 on the global immunization strategy, and the commitment to use the decade 2011–2020 to achieve immunization goals and milestones in vaccine research and development;

Recognizing the importance of immunization as one of the most cost-effective interventions in public health;

Acknowledging the significant achievements of the Expanded Programme on Immunization at the global level, including the eradication of smallpox, major advances towards eradicating poliomyelitis, eliminating measles and rubella, and the control of other vaccine-preventable diseases, such as diphtheria and tetanus;

Noting the contribution of successful immunization programmes towards significant reductions in childhood mortality and improvements in maternal health, and thereby towards the attainment of Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health), and towards cancer prevention;

Recognizing that initiatives such as regional vaccination weeks have contributed towards promoting immunization, advancing equity in the use of vaccines and universal access to vaccination services, and enabling cooperation on cross-border immunization activities;

Recognizing also that the initiative of vaccination weeks, a growing global movement that was first introduced in the Region of the Americas in 2003, is scheduled to be observed simultaneously in WHO’s six regions in April 2012, with the participation of more than 180 Member States, territories and areas;

Acknowledging also the high level of political support and international visibility given so far to regional vaccination week initiatives, and noting that the flexibility of the vaccination week framework allows individual Member States and regions to tailor their participation in accordance with national and regional public health priorities;

Concerned that, despite all the achievements of immunization initiatives, many challenges remain, including maintaining immunization as a fundamental aspect of primary health care, administering vaccines to all vulnerable populations regardless of their location, protecting national immunization programmes against the growing threat of misinformation on vaccines and immunization, and ensuring that national programmes are considered a financial priority for Member States,

\(^{192}\) Document EB130/21.
1. REQUESTS Member States to designate the last week of April, when appropriate, as World Immunization Week;

2. REQUESTS the Director-General:

   (1) to support the annual implementation of World Immunization Week as the overarching framework for all regional initiatives that are dedicated to promoting the importance of vaccination across the life-course and working to assure the universal access of individuals of all ages and in all countries to this essential preventive health service;

   (2) to provide support to Member States in mobilizing the resources necessary to sustain World Immunization Week, and to encourage civil society organizations and other stakeholders to support the initiative.
13.13 Substandard/spurious/falsely-labelled/falsified/counterfeit medical products: report of the Working Group of Member States*

**Document A65/23 (Report by the Secretariat):**

1. The Working Group of Member States on Substandard/Spurious/Falsely-Labelled/Falsified/Counterfeit Medical Products, established by decision WHA63(10), met in Geneva from 25 to 28 October 2011. The report of the Working Group, which is hereby transmitted to the Sixty-fifth World Health Assembly, was considered by the Executive Board at its 130th session in January 2012. The Board then adopted resolution EB130.R13.

**ACTION BY THE HEALTH ASSEMBLY**

2. The Health Assembly is invited to adopt the resolution recommended by the Executive Board in resolution EB130.R13.

**ANNEX**

**REPORT OF THE WORKING GROUP OF MEMBER STATES ON SUBSTANDARD/SPURIOUS/FALSELY-LABELLED/FALSIFIED/COUNTERFEIT MEDICAL PRODUCTS**

1. The Working Group of Member States on Substandard/Spurious/Falsely-Labelled/Falsified/Counterfeit Medical Products met from 25 to 28 October 2011 in Geneva and was chaired by Ambassador H.E. Darlington Mwape (Zambia) with the following Vice-Chairs: Mr Hashim Ubale Yusufu on behalf of Dr Paul Orhii (Nigeria), Mr Bruno Neves (Brazil), Mr Javad Aghazadeh Khoei (Islamic Republic of Iran), Ambassador Gaudenz Silberschmidt (Switzerland), Ms Lucky Slamet (Indonesia) and Dr Ruth Lee Choo Ai (Singapore). The session was attended by 90 Member States and one regional economic integration organization.

2. Under each of the substantive agenda items, the Working Group focused on developing specific recommendations.

3. The Working Group agreed not to discuss the definition of “substandard/spurious/falsely-labelled/falsified/counterfeit medical products”. However, it recalled the discussion that took place at the first session in which the issues of “substandard medical products” and “spurious/falsely-labelled/falsified/counterfeit medical products” were dealt with separately.

4. During its deliberations the Working Group considered the following subjects.

**WHO’s role in measures to ensure the availability of quality, safe, efficacious and affordable medical products**

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193 See Annex.
194 See document EB130/2012/REC/2, summary records of the eleventh and twelfth meetings.
195 See document EB130/2012/REC/1 for the resolution, and for the financial and administrative implications for the Secretariat of the adoption of the resolution.
196 Elected Vice-Chair following the resignation of Professor Konstantin Keller (Germany).
197 See document A/SSFFC/WG/2/2.
5. The Working Group expressed unanimous support for WHO’s fundamental role in measures to ensure the availability of quality, safe, efficacious and affordable medical products.

6. The Working Group expressed concern regarding the lack of sufficient financing for WHO’s work in the area of quality, safety and efficacy of medicines.

7. The Working Group agreed to the continuation and the importance of strengthening of WHO’s activities in this area.

**WHO’s role in the prevention and control of medical products of compromised quality, safety and efficacy such as substandard/spurious/falsely-labelled/falsified/counterfeit medical products from a public health perspective, excluding trade and intellectual property considerations**

8. The Working Group considered the possibility of establishing a subcommittee of the WHO Expert Committee on Specifications for Pharmaceutical Preparations to give technical advice on “substandard/spurious/falsely-labelled/falsified/counterfeit medical products”.

9. There was also discussion about establishing a new Member State mechanism to address “substandard/spurious/falsely-labelled/falsified/counterfeit medical products”, which would draw on expert advice and collaborate with the International Conference of Drug Regulatory Authorities and other stakeholders, as appropriate.

10. The Working Group agreed to recommend that the World Health Assembly set up such a mechanism to address “substandard/spurious/falsely-labelled/falsified/counterfeit medical products” (see annexed a proposed draft resolution and the proposed goal, objectives and terms of reference).

**WHO’s relationship with the International Medical Products Anti-Counterfeiting Taskforce**

11. The Working Group considered WHO’s relationship with the Taskforce and discussed three options, as contained in document A/SSFFC/WG/2/4.

12. There were divergent views expressed with regard to WHO’s involvement in the Taskforce and the options proposed. A way forward on this specific issue could emerge when the new mechanism is considered at the Sixty-fifth World Health Assembly.

13. It was agreed that the proposed new Member State mechanism should promote effective collaboration among Member States and the Secretariat, and would draw on expert advice and collaborate with the International Conference of Drug Regulatory Authorities and other stakeholders, as appropriate in order to address “substandard/spurious/falsely-labelled/falsified/counterfeit medical products” and associated activities.

14. The Working Group recommends that the Executive Board adopt the attached draft resolution for consideration by the Sixty-fifth World Health Assembly.

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198 See document A/SSFFC/WG/2/3.
199 In the present document these are found in, respectively, Appendix 1 and Appendix 2.
200 See document A/SSFFC/WG/2/4.
Appendix 1

[This Appendix contained a draft resolution that was adopted by the Board, after amendment, at its twelfth meeting as resolution EB130.R13]

Appendix 2

**Member State mechanism on substandard/spurious/falsely-labelled/falsified /counterfeit medical products**

Goal, objectives and terms of reference

**General goal**

In order to protect public health and promote access to affordable, safe, efficacious and quality medical products, promote, through effective collaboration among Member States and the Secretariat, the prevention and control of substandard/spurious/falsely-labelled/falsified/counterfeit medical products and associated activities.

**Objectives**

(1) To identify major needs and challenges and make policy recommendations, and develop tools in the area of prevention, detection methodologies and control of “substandard/spurious/falsely-labelled/falsified/counterfeit medical products” in order to strengthen national and regional capacities.

(2) To strengthen national and regional capacities in order to ensure the integrity of the supply chain.

(3) To exchange experiences, lessons learnt, best practices, and information on ongoing activities at national, regional and global levels.

(4) To identify actions, activities and behaviours that result in “substandard/spurious/falsely-labelled/falsified/counterfeit medical products” and make recommendations, including for improving the quality, safety and efficacy of medical products.

(5) To strengthen regulatory capacity and quality control laboratories at national and regional levels, in particular for developing countries and least developed countries.

(6) To collaborate with and contribute to the work of other areas of WHO that address access to quality, safe, efficacious and affordable medical products, including, but not limited to, the supply and use of generic medical products, which should complement measures for the prevention and control of “substandard/spurious/falsely-labelled/falsified/counterfeit medical products”.

(7) To facilitate consultation, cooperation and collaboration with relevant stakeholders in a transparent and coordinated manner, including regional and other global efforts, from a public health perspective.

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The Member State mechanism shall use the term “substandard/spurious/falsely-labelled/falsified/counterfeit medical products” until a definition has been endorsed by the governing bodies of WHO.
(8) To promote cooperation and collaboration on surveillance and monitoring of “substandard/spurious/falsely-labelled/falsified/counterfeit medical products”.

(9) To further develop definitions of “substandard/spurious/falsely-labelled/falsified/counterfeit medical products” that focus on the protection of public health.

Structure

(1) The Member State mechanism will be open to all Member States. The Member State mechanism should include expertise in national health and medical products regulatory matters.

(2) The Member State mechanism may establish subsidiary working groups from among its members to consider and make recommendations on specific issues.

(3) Regional groups will provide input into the Member State mechanism as appropriate.

(4) The Member State mechanism shall make use of existing WHO structures.

Meetings

(1) The Member State mechanism should meet not less than once a year and in additional sessions as needed.

(2) The default venue for the Member State mechanism, and its subsidiary working groups, will be Geneva. Meetings may, however, be held from time to time outside Geneva, taking into account regional distribution, overall cost and cost-sharing, and relevance to the agenda.

Relations with other stakeholders and experts

(1) As needed, the Member State mechanism should seek expert advice on specific topics, following standard WHO procedures for expert groups.

(2) As needed, the Member State mechanism will invite other stakeholders to collaborate and consult with the group on specific topics.

Reporting and review

(1) The functioning of the Member State mechanism shall be reviewed by the World Health Assembly after three years of its operation.

(2) The Member State mechanism shall submit a report to the Health Assembly through the Executive Board on progress and any recommendations annually as a substantive item for the first three years and every two years thereafter.

Transparency and conflict of interest

(1) The Member State mechanism, including all invited experts, should operate in a fully inclusive and transparent manner.

(2) Possible conflicts of interest shall be disclosed and managed in accordance with the policies and practice of WHO.

202 And, where applicable, regional economic integration organizations.
RESOLUTION 13.13: Substandard/spurious/falsely-labelled/falsified/counterfeit medical products: report of the Working Group of Member States

Executive Board Resolution EB130.R13

Substandard/spurious/falsely-labelled/falsified/counterfeit medical products

The Executive Board, RECOMMENDS to the Sixty-fifth World Health Assembly the adoption of the following resolution:

The Sixty-fifth World Health Assembly,

Having considered the report of the Working Group of Member States on Substandard/Spurious/Falsely-Labelled/Falsified/Counterfeit Medical Products and its recommendations; 203, 204

Welcoming the outcome of the sessions of the Working Group of Member States on Substandard/Spurious/Falsely-Labelled/Falsified/Counterfeit Medical Products;

Reaffirming the fundamental role of WHO in ensuring the availability of quality, safe and efficacious medical products;

Recognizing that many people in the world lack access to quality, safe, efficacious and affordable medicines and that such access is an important part of a health system;

Recognizing the importance of ensuring that combating “substandard/spurious/falsely-labelled/falsified/counterfeit medical products” does not result in hindering the availability of legitimate generic medicines;

Recognizing the need, as expressed in the Rio Political Declaration on the Social Determinants of Health (2011), 205 to promote access to affordable, safe, efficacious and quality medicines, including through the full implementation of the WHO global strategy and plan of action on public health, innovation and intellectual property;

Acknowledging the need for improving access to affordable, quality, safe and efficacious medicines as an important element in the effort to prevent and control medicines with compromised quality, safety and efficacy and in the decrease of “substandard/spurious/false-labelled/falsified/counterfeit medical products”;

Taking note of resolution 20/6 of the United Nations Commission on Crime Prevention and Criminal Justice entitled “Countering fraudulent medicines, in particular their trafficking”;

204 A definition of “substandard/spurious/falsely-labelled/falsified/counterfeit medical products” has yet to be endorsed by the governing bodies.
205 See subparagraph 11.2 (xii).
Expressing concern regarding the lack of sufficient financing for WHO’s work in the area of quality, safety and efficacy of medicines;

Recognizing the need to enhance support to national and regional regulatory authorities to promote the availability of quality, safe and efficacious medical products,

1. REAFFIRMS the fundamental role of WHO in ensuring the quality, safety and efficacy of medical products; in promoting access to affordable, quality, safe and efficacious medicines; and in supporting national drug regulatory authorities in this area, in particular in developing countries and least-developed countries;

2. REITERATES that WHO should continue to focus on and intensify its measures to make medical products more affordable, strengthening national regulatory authorities and health systems which includes national medicine policies, health risk management systems, sustainable financing, human resource development and reliable procurement and supply systems; and to enhance and support work on prequalification and promotion of generics, and efforts in rational selection and use of medical products. In each of these areas, WHO’s function should be: information sharing and awareness creation; norms and standards and technical assistance to countries on country situation assessment; national policy development; and capacity building, supporting product development and domestic production;

3. FURTHER REITERATES that WHO should increase its efforts to support Member States in strengthening national and regional regulatory infrastructure and capacity;

4. DECIDES to establish a new Member State mechanism for international collaboration among Member States, from a public health perspective, excluding trade and intellectual property considerations, regarding “substandard/spurious/falsely-labelled/falsified/counterfeit medical products” in accordance with the goals, objectives and terms of reference annexed to the present resolution;

5. FURTHER DECIDES to review the Member State mechanism referred to in operative paragraph 4 after three years of operation;

6. URGES Member States to:

   (1) on a voluntary basis, participate in and collaborate with the Member State mechanism referred to in operative paragraph 4;

   (2) provide sufficient financial resources to strengthen the work of the Secretariat in this area;

7. REQUESTS the Director-General:

   (1) to support the Member State mechanism referred to in operative paragraph 4;

   (2) to assist Member States in building capacity to prevent and control “substandard/spurious/falsely-labelled/falsified/counterfeit medical products”.

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206 And, where applicable, regional economic integration organizations.
207 Attached as Appendix 2 of document A65/23.
208 And, where applicable, regional economic integration organizations.
13.15 **WHO’s response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies**

**Document A65/25  (Report by the Secretariat):**

1. At its 130th session in January 2012, the Executive Board considered an earlier version of this report; the Board then adopted resolution EB130.R14.209

**BACKGROUND**

2. Over the last 10 years, an average of 700 disasters have been reported every year. Annually, an estimated 268 million people are affected by disasters. In 2010, humanitarian emergencies requiring international assistance occurred in 32 countries. The epidemiological profile associated with disasters and conflicts is changing and, although most of the associated mortality continues to be due to infectious diseases, noncommunicable diseases are increasingly among the top five of causes of morbidity and mortality in such settings. Global trends in urbanization are providing a further impetus for the adaptation of intervention strategies.

3. The mandate of WHO in humanitarian emergencies derives from Article 2(d) of the Constitution and resolutions WHA34.26, WHA46.6, WHA48.2, WHA58.1, WHA59.22 and WHA64.10. WHO’s role is substantially influenced by United Nations General Assembly resolution 46/182 on strengthening the coordination of the humanitarian emergency assistance of the United Nations, which was adopted in 1991. The resolution established the Inter-Agency Standing Committee which, chaired by the Emergency Relief Coordinator, is now the key coordinating mechanism for major humanitarian actors including WHO.

4. In working with Member States in the context of humanitarian emergencies, the Organization has focused on twin objectives: to build national capacities for emergency and disaster risk-management and integrate the latter into national health policies, strategies and plans; and to support acute and protracted emergency response activities. The Secretariat’s development work with Member States includes the provision of technical guidance and support for assessing risks and strengthening early warning systems. In addition, support for national and community capacities involves the integration of disaster risk-reduction and preparedness activities into health planning, including promotion of the safe hospitals programme.

5. In 2005 the United Nations General Assembly adopted resolution 60/124 on strengthening of the coordination of emergency humanitarian assistance of the United Nations. Work in response to this has involved: (i) the introduction of further humanitarian reforms, including the “cluster” approach; (ii) financial reforms, including pooled funding mechanisms; and (iii) the strengthening of the humanitarian coordinator function in countries. WHO was proposed to serve as the lead organization for the Inter-Agency Standing Committee Global Health Cluster with the goal of improving the coordination, effectiveness and efficiency of health action in crises.

6. In December 2010, the United Nations Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator, together with the Principals of the Inter-Agency Standing Committee, launched a one-year review - the “transformative agenda” - in order to tackle major deficiencies in the international response to humanitarian emergencies.

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209 See document EB130/2012/REC/2, summary record of the twelfth meeting.
210 See document EB130/2012/REC/1 for the resolution, and for the financial and administrative implications for the Secretariat of the adoption of the resolution.
This initiative was the result of a frank acknowledgement of substantial shortcomings in the leadership, speed and coordination of the response to the mega-emergencies experienced that year in Haiti and Pakistan. Concurrent with both the Inter-Agency Standing Committee’s transformative agenda and its own internal reforms, WHO has undertaken a candid review of its performance in humanitarian response, involving broad consultation across the Organization and partner agencies. The present report summarizes the context for this review and the major findings. It also outlines a proposed way forward, the centrepiece of which is a new WHO emergency response framework that communicates core commitments, performance standards and procedures and policies for enhancing the quality and predictability of the Organization’s response to both public-health and humanitarian emergencies at country level.

**WHO AS GLOBAL HEALTH CLUSTER LEAD AGENCY FOR EMERGENCY HUMANITARIAN ASSISTANCE**

7. In 2003, in order to scale up the Organization’s capacity and competency to meet its expanded responsibilities in responding to humanitarian emergencies, WHO established the health action in crises cluster. Standard operating procedures were adopted to prioritize and accelerate administrative procedures in support of emergency operations; a partnership agreement was established with WFP to allow the stockpiling and rapid deployment of medical supplies from four regional warehouses; and a training process was initiated and a roster of experts developed, with eventual expansion to include Health Cluster Coordinators. Working groups were also established to draw on resources and expertise from all areas of the Organization in support of both longer-term and acute technical needs and an orientation programme on health cluster management was developed for heads of WHO country offices and integrated into their induction training course. Between 2005 and 2006 WHO assumed its leadership role in the Global Health Cluster, which centred on building consensus on health priorities, policies and best practices in humanitarian emergencies and strengthening the capacity of all health sector stakeholders to deliver effective and predictable responses. WHO established a secretariat for the Global Health Cluster in order to facilitate dialogue between the members and to convene an annual meeting of the Cluster, which is currently made up of almost 40 international humanitarian health organizations.

8. Based on generic terms of reference that have been defined by the Inter-Agency Standing Committee to guide and measure the work of clusters at country level, the Global Health Cluster defined 10 core functions and benchmarks for its performance in countries. Within the health cluster at country level, particular emphasis is given to ensuring that health partners jointly assess and analyse information, prioritize interventions, build an evidence-based strategy and action plan, monitor the health situation and health-sector response, adapt or replan as necessary, mobilize resources and perform advocacy for humanitarian health action. As lead agency for the cluster at country level, WHO also has the responsibility to act as provider of last resort. Ideally, the Ministry of Health co-chairs meetings of the health cluster. Where this has not been possible, WHO has chaired the meetings, often in concert with a nongovernmental organization. The Head of the WHO Country Office represents the health cluster in the humanitarian country team, supported by a Health Cluster Coordinator.

9. Since 2005, the Emergency Relief Coordinator has activated the cluster approach in a total of 43 countries; in 31 of these the approach is still active, including the health cluster. In large-scale crises, such as those that occurred in Haiti and Pakistan in 2010, more than 300 humanitarian agencies may be registered under the health cluster, posing enormous challenges for coordination. In these settings, WHO has had a dual role of managing the health cluster and implementing its technical functions, particularly the provision of policy guidance and health information management, including the
compilation of health data on mortality, morbidity, nutritional status and health services delivery.

10. As Global Health Cluster lead, and working with partners, WHO has elaborated the health components in the Consolidated Appeal Process. Health sector requirements in these appeals increased from US$ 718 million in 2006 to US$ 1400 million in 2010, with the funding received covering 32% of requirements in 2006 and 56% of those in 2010. WHO’s programmes within these appeals were on average funded at 42%. As at 30 September 2011, WHO had received US$ 272 million in extrabudgetary contributions for humanitarian emergencies in respect of the biennium 2010-2011. This sum includes US$ 79 million from the United Nations Central Emergency Response Fund and US$ 35.5 million from country-based pooled funds.

CHALLENGES EXPERIENCED IN RESPONDING TO HEALTH NEEDS IN HUMANITARIAN EMERGENCIES

11. The Secretariat has encountered a combination of capacity, operational and financial difficulties in optimizing its support to Member States and affected populations during acute humanitarian emergencies, and in discharging fully the functions of the health cluster.

12. First, the Secretariat has experienced difficulties in identifying and deploying adequately trained health cluster coordinators, technical experts and support staff in adequate numbers and with sufficient speed to enable both the health cluster and the technical support functions of the Organization to be scaled up and sustained. This difficulty is particularly acute during large-scale humanitarian emergencies. As a result, the quality and completeness of rapid needs assessments, gap analyses, sector strategies, appeals and performance monitoring have been compromised.

13. Secondly, the Organization has had difficulty balancing its function as the lead agency coordinating the health cluster with its role as a cluster partner providing technical support - an inherent problem at country level. For example, in some emergencies it has proved difficult for the health cluster to fulfill its health information function as cluster partners have not all adhered to agreed common protocols for data collection, while some national authorities have been reluctant to disseminate potentially sensitive health data.

14. The third difficulty experienced derives from the limited operational capacity of WHO, as a United Nations technical specialized agency, to meet the full range of expectations of Member States, members of the Inter-Agency Standing Committee, cluster partners and donors with regard to direct programme implementation in acute humanitarian emergencies. For example, although WHO is able to provide appropriate policy guidance and establish functional early warning and response systems for diseases, the Organization’s structure does not allow it to implement major field-level operations, particularly for the direct delivery of life-saving interventions. In some settings, WHO’s efforts to provide basic services may have compromised its core functions in the areas of health-sector coordination, information, surveillance and policy.

15. The fourth major problem has been insufficient financing, particularly for dedicated health cluster functions. Although donors supporting humanitarian action now expect cluster lead agencies to integrate the funding of cluster coordinators and cluster functions into the mainstream of their funding, this is not possible for a United Nations technical specialized agency such as WHO, which requires dedicated funding for this purpose.

16. A fifth issue concerns the fact that most health clusters have no clear process or criteria governing their deactivation or transition to another arrangement in response to,
respectively, the resolution of an acute emergency or its transformation into a protracted emergency. As a result, health clusters have difficulty making the transition to more appropriate mechanisms for managing the health needs of the affected population, either through a proper recovery programme or by means of a programme of work that is adapted to a protracted emergency and that provides for at least a minimum level of predictable service delivery.

**STRENGTHENING WHO’S RESPONSE TO HUMANITARIAN EMERGENCIES**

17. Over the last 10 years, the Organization has invested significant resources in order to build the Secretariat’s capacity to support Member States and health cluster partners to prepare for and respond to the health needs of people affected by disasters and emergencies. However, in view of the challenges mentioned above, the continuing work on humanitarian reform and the Organization’s own reforms, WHO needs to become faster, more effective and more predictable in delivering high-quality action in response to humanitarian emergencies, with clear benchmarks for measuring performance. In mid-2011 WHO undertook an internal and external consultative process as a basis for enhancing its work in response to humanitarian emergencies, particularly given the acute financing gap for WHO’s core functions in emergency risk management.

18. This consultative process informed the development of a new, cross-organizational approach to improve the speed, consistency and predictability of WHO’s response to both humanitarian and public health emergencies. Central to this approach is a new WHO emergency response framework that will serve as a common operational platform for the Organization’s work in such emergencies. The major elements of the new framework are: 

(a) a clear statement of WHO’s core commitments in acute emergencies, for which the Organization will be accountable, emphasizing the Organization’s central role in respect of partner coordination, expert policy and technical advice, information, and communicable disease surveillance and control;  
(b) performance standards and timelines for measuring the speed and quality of WHO’s work within an emergency response, with the enunciation of key deliverables to be provided within, for example, 12 hours, 72 hours, 7 days and 14 days;  
(c) a process and criteria for grading the local capacity to respond to an emergency so that all acute emergencies can be classified within 12 hours in terms of the support that a country office will require from each level of the Organization, with coordination through a global emergency management team comprising emergency focal points from all six regional offices and headquarters;  
(d) common WHO emergency response procedures that clarify the management of WHO’s major functions in emergencies, including the roles and responsibilities of each level of the Organization, in order to ensure that in an acute emergency WHO’s key leadership, information, technical and enabling functions can be competently and rapidly performed at country level; and  
(e) WHO emergency policies in the areas of surge capacity, application of the “no-regrets” principle and the appointment and deployment of a prequalified “health emergency leader” to help country offices to ensure a more predictable response to major emergencies, building on the experience of other United Nations agencies and the reforms of the Inter-Agency Standing Committee’s response to major humanitarian emergencies that were undertaken in 2011.

19. The full application of a new WHO corporate approach to emergencies will require further investments. These will be needed at the headquarters and regional levels, and in countries affected by protracted and repeated emergencies, so that the necessary core staffing for the management of such a programme of work can be established and sustained. At the global level, the programmes of the health action in crises cluster have

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211 According to this principle, practices and actions for dealing with expected problems are supported even if the problems concerned are not yet certain to occur.
been restructured and adapted to form the new Department of emergency risk management and humanitarian response. This streamlined structure was established to deliver more efficiently the five key global functions that were identified in WHO’s consultative process and which fall into two categories, as follows: (a) technical functions - intelligence, information and monitoring; policy, practice and evaluation; and surge and crisis support; and (b) core programme functions - resource management; and external relations. Under this new structure, the Department will focus on coordinating and managing WHO’s broader assets in the context of humanitarian emergencies, with a strong emphasis on a coordinated programme of work, involving the Secretariat cluster responsible for health security and environment and regional counterparts, particularly in the areas of emergency risk reduction, preparedness and emergency response. In 2012, the Organization is focusing on operationalizing the new corporate approach to humanitarian response, at all levels and in keeping with the 2011 reforms of the Inter-Agency Standing Committee. This effort includes a year-end review of lessons learnt and will involve further reform, if required.

20. At the interagency level, further policy work is required to establish guidelines for deactivating health clusters and transitioning more rapidly either to an early recovery approach or, for protracted emergencies, to a coordinating mechanism that is more appropriate for ensuring the predictable delivery of basic health services. This will require WHO to provide effective support to national authorities in implementing a formal recovery plan or transition process, and to work with health cluster partners, enabling them to align their programmes with national policies.

21. Strengthening resilience from the level of national institutions down to local communities is fundamental to improving health outcomes in humanitarian emergencies. In 2012, WHO is undertaking a further consultative process to inform the development of a stronger and more comprehensive programme of work in emergency risk management, encompassing emergency risk reduction, national emergency preparedness, institutional readiness and institutional business continuity planning.

**ACTION BY THE HEALTH ASSEMBLY**

22. The Health Assembly is invited to provide guidance on the continuing reform of WHO’s work in response to humanitarian emergencies, and to adopt the resolution recommended by the Executive Board in resolution EB130.R14.

**RESOLUTION 13.15: WHO’s response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies**

**Executive Board Resolution EB130.R14**

The Executive Board, having considered the report on WHO’s response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies, RECOMMENDS to the Sixty-fifth World Health Assembly the adoption of the following resolution:

The Sixty-fifth World Health Assembly,

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212 Document EB130/24.
Having considered the report on WHO’s response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies;

Recognizing that humanitarian emergencies result in avoidable loss of life and human suffering, weaken the ability of health systems to deliver essential life-saving health services, produce setbacks for health development and hinder the achievement of the Millennium Development Goals;

Reaffirming the principles of neutrality, humanity, impartiality and independence in the provision of humanitarian assistance, and reaffirming the need for all actors engaged in the provision of humanitarian assistance in situations of complex humanitarian emergencies and natural disasters to promote and fully respect these principles;

Recalling Article 2(d) of the Constitution of the World Health Organization on the mandate of WHO in emergencies, and resolutions WHA58.1 on health action in relation to crises and disasters and WHA59.22 on emergency preparedness and response;213

Recalling United Nations General Assembly resolution 46/182 on the strengthening of the coordination of humanitarian emergency assistance of the United Nations and the guiding principles thereof, confirming the central and unique role for the United Nations in providing leadership and coordinating the efforts of the international community to support countries affected by humanitarian emergencies, establishing, inter alia, the Inter-Agency Standing Committee, chaired by the Emergency Relief Coordinator, supported by the United Nations Office for the Coordination of Humanitarian Affairs;

Taking note of the humanitarian response review in 2005, led by the Emergency Relief Coordinator and by the Principals of the Inter-Agency Standing Committee aiming at improving urgency, timeliness, accountability, leadership and surge capacity, and recommending the strengthening of humanitarian leadership, the improvement of humanitarian financing mechanisms and the introduction of the clusters as a means of sectoral coordination;

Taking note of the Inter-Agency Standing Committee Principals’ Reform Agenda 2011-2012 to improve the international humanitarian response by strengthening leadership, coordination, accountability, building global capacity for preparedness and increasing advocacy and communications;

Recognizing United Nations General Assembly Resolution 60/124, and taking note of WHO’s subsequent commitment to supporting the Inter-Agency Standing Committee transformative humanitarian agenda and contributing to the implementation of the Principals’ priority actions designed to strengthen international humanitarian response to affected populations;

Reaffirming that it is the national authority that has the primary responsibility to take care of victims of natural disasters and other emergencies occurring on its territory, and that the affected State has the primary role in the initiation, organization, coordination, and implementation of humanitarian assistance within its territory;

Taking note of the 2011 Inter-Agency Standing Committee guidance note on working with national authorities, that clusters should support and/or complement existing national coordination mechanisms for response and preparedness and where appropriate,

213 Resolutions WHA34.26, WHA46.6, WHA48.2, WHA58.1, WHA59.22 and WHA64.10 reiterate WHO’s role in emergencies.
government, or other appropriate national counterparts should be actively encouraged to co-chair cluster meetings with the Cluster Lead Agency;

Recalling resolution WHA64.10 on strengthening national health emergency and disaster management capacities and resilience of health systems, which urges Member States, inter alia, to strengthen all-hazards health emergency and disaster risk-management programmes;

Reaffirming also that countries are responsible for ensuring the protection of the health, safety and welfare of their people and for ensuring the resilience and self-reliance of the health system, which is critical for minimizing health hazards and vulnerabilities and delivering effective response and recovery in emergencies and disasters;

Recognizing the comparative advantage of WHO through its presence in, and its relationship with Member States, and through its capacity to provide independent expertise from a wide range of health-related disciplines, its history of providing the evidence-based advice necessary for prioritizing effective health interventions, and that the Organization is in a unique position to support health ministries and partners as the global health cluster lead agency in the coordination of preparing for, responding to and recovering from humanitarian emergencies;

Recalling WHO’s reform agenda and taking note of the report in 2011 by the Director-General on Reforms for a healthy future, which led to the creation of a new WHO cluster, Polio, Emergencies and Country Collaboration, aimed at supporting regional and country offices to improve outcomes and increase WHO’s effectiveness at the country level, by redefining its commitment to emergency work and placing the cluster on a more sustainable budgetary footing;

Welcoming the reform in 2011 transforming the WHO cluster Health Action in Crisis into the Emergency Risk Management and Humanitarian Response department as a means of implementing these reforms, ensuring that the Organization becomes faster, more effective and more predictable in delivering higher quality response in health, and that the Organization holds itself accountable for its performance;

Recalling resolutions WHA46.39 on health and medical services in times of armed conflict; WHA55.13 on protection of medical missions during armed conflict; and the United Nations General Assembly resolution 65/132 on safety and security of humanitarian personnel and protection of United Nations personnel, considers that there is a need of systematic data collection on attacks or lack of respect for patients and/or health workers, facilities and transports in complex humanitarian emergencies;

1. CALLS ON Member States and donors:

   (1) to allocate resources for the health sector activities during humanitarian emergencies through United Nations Consolidated Appeal Process and Flash Appeals, and for strengthening WHO’s institutional capacity to exercise its role as the Global Health Cluster Lead Agency and to assume health cluster lead in the field;

   (2) to ensure that humanitarian activities are carried out in consultation with the country concerned for an efficient response to the humanitarian needs, and to

\[214\] Document A64/4.
\[215\] And, where applicable, regional economic integration organizations.
encourage all humanitarian partners, including nongovernmental organizations, to participate actively in the health cluster coordination;

(3) to strengthen the national level risk management, health emergency preparedness and contingency planning processes and disaster management units in the health ministry, as outlined in resolution WHA64.10, and, in this context, as part of the national preparedness planning, with the Office for the Coordination of Humanitarian Affairs where appropriate, identify in advance the best way to ensure that the coordination between the international humanitarian partners and existing national coordination mechanisms will take place in a complementary manner in order to guarantee an effective and well-coordinated humanitarian response;

(4) to build the capacity of national authorities at all levels in managing the recovery process in synergy with the longer-term health system strengthening and reform strategies, as appropriate, in collaboration with WHO and the health cluster;

2. CALLS ON the Director-General:

(1) to have in place the necessary WHO policies, guidelines, adequate management structures and processes required for effective and successful humanitarian action at the country level, as well as the organizational capacity and resources to enable itself to discharge its function as the Global Health Cluster Lead Agency, in accordance with agreements made by the Inter-Agency Standing Committee Principals; and assume a role as Health Cluster Lead Agency in the field;

(2) to strengthen WHO’s surge capacity, including developing standby arrangements with Global Health Cluster partners, to ensure that WHO has qualified humanitarian personnel to be mobilized at short notice when required;

(3) to ensure that in humanitarian crises WHO provides Member States and humanitarian partners with predictable support by coordinating rapid assessment and analysis of humanitarian needs, including as a part of the coordinated Inter-Agency Standing Committee response, building an evidence-based strategy and action plan, monitoring the health situation and health sector response, identifying gaps, mobilizing resources and performing the necessary advocacy for humanitarian health action;

(4) to define the core commitments, core functions and performance standards of the Organization in humanitarian emergencies, including its role as the Global Health Cluster Lead Agency and as Health Cluster Lead Agency in the field, and to ensure full engagement of country, regional and global levels of the Organization to their implementation according to established benchmarks, keeping in mind the ongoing work on the Inter-Agency Standing Committee transformative humanitarian agenda;

(5) to provide a faster, more effective and more predictable humanitarian response by operationalizing the Emergency Response Framework, with the performance benchmarks in line with the humanitarian reform, and to ensure the accountability of its performance against those standards;

(6) to establish necessary mechanisms to mobilize WHO’s technical expertise across all disciplines and levels, for the provision of necessary guidance and support to Member States, as well as partners of the health cluster in humanitarian crises;

(7) to support Member States and partners in the transition to recovery, aligning the recovery planning, including emergency risk management as well as disaster risk-
reduction and preparedness, with the national development policies and ongoing health sector reforms, and/or using the opportunities of post-disaster and/or post-conflict recovery planning;

(8) to provide leadership at the global level in developing methods for systematic collection and dissemination of data on attacks on health facilities, health workers, health transports, and patients in complex humanitarian emergencies, in coordination with other relevant United Nations bodies, the International Committee of the Red Cross, and intergovernmental and nongovernmental organizations, avoiding duplication of efforts;

(9) to provide a report to the Sixty-seventh World Health Assembly, through the Executive Board, and thereafter every two years, on progress made in the implementation of this resolution.
13.16 Progress Reports

Extract from Document A65/26 (Report by the Secretariat):

H. PREVENTION AND CONTROL OF MULTIDRUG-RESISTANT TUBERCULOSIS AND EXTENSIVELY DRUG-RESISTANT TUBERCULOSIS (resolution WHA62.15)

97. In resolution WHA62.15 the Health Assembly urged Member States to achieve universal access to diagnosis and treatment of multidrug-resistant and extensively drug-resistant tuberculosis and requested WHO to support the process. Considerable progress has been made and 26 of the 27 Member States that account for more than 85% of incident cases of multidrug-resistant tuberculosis globally currently have plans to expand access to care. In September 2011, the Regional Committee for Europe adopted the Consolidated action plan to prevent and combat multidrug- and extensively drug-resistant tuberculosis in the WHO European Region 2011-2015 (resolution EUR/RC61/R7).

98. Partly to prevent the development of drug-resistant tuberculosis, all 22 countries with a high burden of tuberculosis have adopted WHO-recommended strategies to engage relevant care providers in tuberculosis control through public-private collaboration. In 2011, between 20% and 40% of notifications of cases of tuberculosis were reported by health-care providers outside national tuberculosis programmes in 20 countries (including 10 with a high burden of tuberculosis) in areas implementing mixed public-private approaches. As quality-assured medicines are essential to prevent and treat drug-resistant tuberculosis, WHO has provided technical assistance and strategic advice on quality standards and regulatory issues to manufacturers and regulatory authorities in more than 70 countries.

99. Between 2008 and 2011, WHO introduced new policies on programmatic management of drug-resistant tuberculosis and new laboratory diagnostic tools, and endorsed six additional drug-susceptibility testing technologies, including the Xpert MTB/RIF assay, a new molecular technique to diagnose both tuberculosis and resistance to rifampicin in less than two hours. WHO has produced guidance for countries on the use of these tests and is coordinating the Expanding Access to New Diagnostics for TB project which aims at improving access to drug-susceptibility testing in 27 priority countries. Technology transfer is complete or under way in 18 of these countries. By the end of 2011, 40 developing countries had implemented Xpert MTB/RIF technology.

100. In 2011, a new global framework was launched in order to coordinate the support provided by WHO and partners to countries for expanding access to care for patients with multidrug-resistant tuberculosis. All countries are now eligible to procure quality-assured second-line antituberculosis medicines directly through the Global Drug Facility (the WHO-supported procurement mechanism), but their cost remains too high. Two new antituberculosis medicines are expected to enter into clinical use around 2013, and WHO is working on a policy for their rational introduction and use.

101. WHO provides support to countries in monitoring access to care for multidrug-resistant tuberculosis and in modernizing information technology systems in use for this purpose. Some 21 countries with a high burden of tuberculosis are using or planning to adopt electronic systems for the management of data, and 10 are planning, have recently started or have completed surveys of drug resistance in order to improve the accuracy of information available.

102. Despite this progress, the current pace of improvements will not lead to achievement of the targets set in resolution WHA62.15. Globally, only about 6% of basic
health care units providing care for tuberculosis patients also provide care for those with multidrug-resistant disease. Overall notification of cases of multidrug-resistant tuberculosis increased from 29 000 in 2008 to about 53 000 in 2010, but it remains well below target (see Figure). About 290 000 multidrug-resistant tuberculosis cases could be detected each year if all notified tuberculosis patients could be tested for drug susceptibility, but only about 46 000 patients with multidrug-resistant tuberculosis (16% of the estimated total) were reported to have been enrolled in treatment programmes in 2010 and of these only 13 000 are being treated according to WHO standards.

103. Countries must urgently commit more funding to tuberculosis programmes, increase access to affordable rapid diagnostics, and treat more of their drug-resistant tuberculosis patients. The costs of treatment must be lowered and the production capacity of quality-assured second-line medicines increased. Programmatic capacity for managing tuberculosis patients must also be strengthened through implementation of the policy set out in resolution WHA62.15.

104. At its 130th session in January 2012 the Executive Board noted an earlier version of this progress report; during the discussions, reference was made to the need for Member States to intensify the response to multidrug-resistant tuberculosis. A recent study of people in India infected by forms of virtually untreatable, multidrug-resistant tuberculosis gives an indication of the risks to which countries could be exposed if implementation of resolution WHA62.15 is not accelerated.

M. REPRODUCTIVE HEALTH: STRATEGY TO ACCELERATE PROGRESS TOWARDS THE ATTAINMENT OF INTERNATIONAL DEVELOPMENT GOALS AND TARGETS (resolution WHA57.12)

138. At its 130th session in January 2012 the Executive Board noted an earlier version of this progress report.

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216 See document EB130/2012/REC/2, summary record of the fourteenth meeting, section 2.
218 See document EB130/2012/REC/2, summary record of the fourteenth meeting, section 2.
139. In resolution WHA57.12, the Health Assembly requested the Director-General to devote sufficient organizational priority, commitment and resources to supporting effective promotion and implementation of the reproductive health strategy; to provide support to Member States in ensuring reproductive health commodity security; and report at least biennially. In September 2010, the United Nations Secretary-General launched the Global Strategy for Women’s and Children’s Health, refocusing attention on the critical role of reproductive health in the overall health of women and children, and re-emphasizing the need to accelerate progress.

140. The Secretariat continues to collaborate with Member States in efforts to achieve universal access to and quality of sexual and reproductive health care. Regional work includes support to policy frameworks and acceleration plans on improving reproductive health and contributing to ministerial and parliamentary summit outcome documents on reproductive health and development. Technical support is being provided in a number of areas, including health-care financing, policy dialogue, human resources, and in strengthening capacity for service delivery needs in the key components of sexual and reproductive health.

141. A WHO questionnaire was administered in 2011 among Member States to assess implementation of the global reproductive health strategy. The results indicate that progress has been made. Among the 58 Member States that responded to the survey, progress had been facilitated by:

- strengthening partnerships aimed at improving health-system capacity, training and retaining skilled health workers, and increasing access to emergency obstetric care;
- updating legislative and regulatory frameworks aligned with national strategic plans;
- gaining political commitment through demonstrating the vital connection between improved reproductive health and development;
- strengthening monitoring, evaluation and accountability to improve the evidence base for priority setting; and
- allocating national resources for reproductive health: over 50% of the countries surveyed had procedures in place to monitor resource flows.

142. The results of the survey also show that increasingly interventions developed by WHO to reduce maternal mortality and improve reproductive health were being put into practice. More than 85% of countries that responded indicated that targeted antenatal care had been integrated into reproductive/maternal health programmes; in 95%, magnesium sulphate is registered for use in reducing deaths from eclampsia, which is a significant improvement compared with findings of the survey conducted in 2009; and in more than 95%, reproductive health essential medicines were in the national essential medicines list. Only about two thirds, however, included emergency contraception among contraceptive methods provided through public health programmes; and only three quarters reported screening for early detection of cervical cancer. Screening for congenital syphilis during pregnancy was still not universal.

143. At the same time, Member States identified barriers to the improvement of reproductive health services. These barriers include: political instability or crisis; poor quality of care; poor coordination of efforts; insufficient human resources and poorly motivated staff; lack of funds and commodities; poverty; low levels of community engagement; and sociocultural factors.

144. Such barriers also contribute to uneven progress and account for the observed disparities in reproductive health outcomes, including the varied rates of reducing maternal mortality across regions. Globally, the annual reduction in the maternal mortality...
mortality ratio was 2.3% between 1990 and 2008. In the South-East Asia Region and Western Pacific Region, the estimated decline in the annual maternal mortality ratio was 5%. It was 1.7% and 1.5% in the African Region and the Eastern Mediterranean Region, respectively. The slower progress in reducing maternal mortality in sub-Saharan Africa relative to Asia, together with an increasing number of births, has resulted in a major regional shift in the burden of maternal mortality. In 1990, around 58% of global maternal deaths occurred in Asia and 36% in sub-Saharan Africa; in 2008, this trend had reversed, with an estimated 39% of global maternal deaths occurring in Asia and 57% in sub-Saharan Africa.

145. Access to care through pregnancy and childbirth is crucial for reducing maternal deaths and improving maternal health. The proportion of childbirths attended by skilled health personnel increased from 61% in the 1990s to 66% in the 2000s, globally. Despite the dramatic progress made in many regions, coverage (i.e. the proportion of childbirths where skilled attendants are present) remains low in the South-East Asia Region and the African Region, where the majority of maternal deaths occur. Inequities exist according to place of residence: in recent years, the median value for the proportion of births attended by a skilled health professional is 63% in rural areas compared with 89% in urban areas.

146. Family planning is a key component of sexual and reproductive health and can prevent up to one third of maternal deaths. Although contraceptive use among women who are married or in union is over 60% globally, large differences are seen across regions. Women in sub-Saharan Africa have the lowest levels of contraceptive use (22% in 2008). The unmet need for family planning, that is, the gap between women who wish to delay or stop childbearing and those who do not use any contraceptive method, has been unchanged in sub-Saharan Africa since 1990: 26% in 1990, and 25% in 2008. Within countries, the unmet need is associated with household wealth, with poorer women having a higher unmet need.

147. Pregnancy presents a risk of adverse health and social consequences for adolescents, especially as they are less likely to have access to reproductive health services. Data for 22 countries in sub-Saharan Africa for 1998–2008 show that women aged 15–19 years who are married or in a union have much lower levels of contraceptive use than all women of reproductive age who are married or in a union (10% and 21%, respectively), and similar levels of unmet need for contraception (around 25%). Thus, the proportion of adolescents having their demand met for contraception is much lower than that of their older counterparts (29% compared with 45%).

148. Adolescent boys and men are also in need of sexual and reproductive health services and information. Less than 40% of young men in developing regions know that two ways of avoiding sexually transmitted infections are condom use and either abstinence or having only one, uninfected partner. The proportion of young men reporting that they had used a condom at last high-risk sex varies from 38% in southern Asia to 56% in the Caribbean. Sexuality education programmes have been shown to have a significant effect on reducing high-risk sexual behaviours.

221 See document EB130/12 for a more detailed discussion about the birth rate among adolescents, which remains high in sub-Saharan Africa (122 births per 1000 women aged 15-19 years). Despite a decline in total fertility in Latin America, the Caribbean and southern Asia, adolescent fertility continues to be high in these regions.
O. CLIMATE CHANGE AND HEALTH (resolutions EB124.R5 and WHA61.19)

164. At its 130th session in January 2012, the Executive Board noted an earlier version of this progress report.²²⁴

165. The present report responds to resolution EB124.R5, in which the Executive Board requested the Director-General to report on progress in implementing resolution WHA61.19 and the workplan on climate change and health. The report also updates the information provided to the Health Assembly in May 2011.²²⁵

166. Promoting and supporting the generation of scientific evidence. The Secretariat has worked closely with WMO, holding a consultation meeting and providing technical input to the health component of the new Global Framework for Climate Services. WHO staff continue to contribute to the Intergovernmental Panel on Climate Change Special Report on extreme events²²⁶ and to the forthcoming Fifth Assessment Report. The Secretariat continues to work to identify the likely health benefits of strategies to reduce greenhouse gas emissions from key sectors assessed by the Panel, and has published reports on the housing²²⁷ and transport²²⁸ sectors. WHO has produced new technical reports and guidance on subjects that include vulnerability and adaptation assessment²²⁹ and gender, climate change and health.³²⁰ A guidance package on health responses to heatwaves has also been published.²³¹

167. Advocacy and awareness raising. The Secretariat has worked with Member States to emphasize the importance of health in climate change policy, and the linkages between climate change and other environmental and social determinants of health. This effort has included events at the Sixty-third World Health Assembly, the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 19-21 October 2011) and the 17th Conference of the Parties to the United Nations Framework Convention on Climate Change (Durban, South Africa, 28 November-9 December 2011). The Secretariat coordinates a contact group of national delegates to the Framework Convention in order to promote consideration of health within the negotiations, and has established a consultation group of health-professional associations and nongovernmental organizations in order to generate and disseminate information for health advocacy. The Secretariat has also updated an audit of the carbon footprint of selected WHO offices as part of the United

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²²⁴ See documents EB130/35 Add.1 and EB130/2012/REC/2, summary record of the fourteenth meeting.
²²⁵ Document A64/26.
²²⁶ Intergovernmental Panel on Climate Change. WMO. UNEP. Special report: Managing the risks of extreme events and disasters to advance climate change adaptation (http://ipcc-wg2.gov/SREX/, accessed 23 February 2012).
Nations “Greening the Blue” initiative, and is now considering policy proposals to reduce emissions.

168. **Strengthening health systems to protect populations from the adverse impacts of climate change on health.** WHO has gained ministerial endorsement for new frameworks for protecting health from climate change in the African Region and in the Region of the Americas, which will guide national health systems’ adaptation plans. The Secretariat has completed assessments of health vulnerability and consequent adaptation needs in over 30 countries. A seven-country global pilot project on public health adaptation to climate change (involving Barbados, Bhutan, China, Fiji, Jordan, Kenya and Uzbekistan) has run its first year. In addition, the Regional Office for Europe has completed the second year of a health systems adaptation project that it is coordinating in central Asia and eastern Europe (covering Albania, Kazakhstan, Kyrgyzstan, the Russian Federation, Tajikistan, the former Yugoslav Republic of Macedonia and Uzbekistan), while work on the health components of United Nations country team projects in China, Jordan and the Philippines is also entering its third year. Finally, WHO has initiated a new large-scale project on climate change and vector-borne disease in the Western Pacific Region.

169. **Partnership with organizations of the United Nations system and other parties.** WHO has contributed the health perspective to the response of different United Nations bodies to climate change, including the following: the United Nations System Chief Executives Board for Coordination; the United Nations High-Level Committee on Programmes; the Conference of the Parties to the United Nations Framework Convention on Climate Change and its associated policy and technical meetings; and the High-Level Committee on Programmes Task Team on the Social Dimensions of Climate Change, which WHO co-organizes. The Organization also leads activities to design regional frameworks on climate change and health, and convenes intersectoral steering committees to implement national climate and health projects. As a result, health is now recognized as one of the core sectors in global adaptation efforts.

170. The Secretariat supports these activities through a capacity-building programme including training materials, a database of national expertise, guidance on access to funding sources, a toolkit for programme managers on public health adaptation, and a clearing house of existing public health systems’ adaptation projects.

Q. MULTILINGUALISM: IMPLEMENTATION OF ACTION PLAN (resolution WHA61.12)

**Staff language skills database**

179. In 2008, the Health Assembly, in resolution WHA61.12, requested the Director-General, inter alia, to ensure the establishment of a database of the official languages of the Organization in which staff members in the professional category were fluent. This request was fulfilled by the creation of a database that members of staff can access through the WHO Intranet in order to edit and update their language profiles. The database, which has been available to all staff in the Organization since September 2011, was enhanced to permit the reporting of language skills other than fluency. The addition of a search function has also allowed staff members to identify colleagues with skills in a particular language.

180. As at 17 February 2012, more than 1000 staff members, whose locations cover headquarters, the regional offices and some country offices, have entered their language data. Of these, almost half are staff members in the professional and higher categories. The data entered so far show that: 12% of respondents are fluent in Arabic, 2% in Chinese,
96% in English, 53% in French, 5% in Russian and 15% in Spanish. In addition, staff members report having some level of competency in more than 160 languages other than the official languages.

**Exhibition on multilingualism**

181. On 13 May 2011, the Secretariat launched a library exhibition on multilingualism, aiming to promote language diversity and raise awareness about the role of multilingualism in achieving WHO’s global health objectives. The exhibition featured a series of 17 posters, a quiz to guess the language of 16 WHO books, and a video showing testimonials from end-users of WHO’s multilingual information in the Western Pacific Region. As at May 2011, WHO’s publications had been translated into more than 77 different languages, and many examples were displayed at the exhibition.

**The WHO web site**

182. A new web page on multilingualism on the WHO web site\(^2\) promotes multilingual communication as a tool for improving global health.

183. The multilingual team of web editors prioritizes content for the official languages on the basis of statistics for texts being accessed on the web site in the six official languages, direct feedback from web users, and the thematic priorities of the Organization. The team has been functioning without dedicated editors for some official languages, making it difficult to sustain the current workload.

**Institutional Repository for Information Sharing**

184. The Institutional Repository for Information Sharing is a digital library providing open and online access to all WHO’s published material, through a multilingual interface.\(^3\) In November 2011, at the special session of the Executive Board on WHO reform, this effort gained further impetus with a number of Member States requesting that WHO make governing bodies documentation more broadly accessible in a full-text, searchable, digital library, in order to facilitate rapid retrieval.\(^4\) The Institutional Repository was demonstrated to Member States in a side event at the 130\(^{th}\) session of the Executive Board in January 2012. The documents it contains are searchable in official languages by any keywords, and are enriched with full descriptions (metadata) and subject headings (controlled vocabularies) in order to allow for better integration within topical WHO web sites and to ensure that they can be found through Internet search engines.

**Language services**

185. Language services are the main multilingual resource of the Organization. Recent increases in the number of sessions of the governing bodies and in the volume of associated documentation have made the interpretation and translation workload heavier. At the same time, however, the need for high-quality translation of technical documents continues. In 2011, interpretation was provided for 108 meetings over 216 calendar days, totalling 2870 interpreter-days of work, and, given resource constraints, the freelance market is a strategically important source of services. WHO is the lead agency for the United Nations System Chief Executives Board for Coordination in renegotiating the

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\(^3\) The proposal for an institutional repository is described in document EB121/6, which was noted by the Executive Board at its 121\(^{st}\) session (see document EB121/2007/REC/1, summary record of the thirteenth meeting, section 4).

\(^4\) See document EBSS/2/2011/REC/1, summary record of the third meeting.
agreement with the International Association of Conference Translators, and is actively involved in the renegotiation of the parallel agreement with the International Association of Conference Interpreters. The aim is to assure quality and ensure continuity of service from external contractors in the future.

186. The Regional Office for Europe has produced localized versions of the English style guide in French, German and Russian. Similarly, the Regional Office for the Eastern Mediterranean has produced a version in Arabic.

**Report of the United Nations Joint Inspection Unit**

187. In June 2010, WHO contributed to the preparation of the report of the Joint Inspection Unit of the United Nations system on multilingualism in United Nations System Organizations, which is currently being finalized.

**Language learning**

188. Language training continues to be offered to staff members free of charge. During the biennium 2010-2011, enrolments in language courses at headquarters totalled 1844: 84 were for Arabic, 24 for Chinese, 225 for English, 1109 for French, 49 for Russian and 353 for Spanish.
WHO Reform

Extract from Document A65/40  (Report by the Director-General):

The Director-General has the honour to transmit to the Sixty-fifth World Health Assembly the report by the Chairman of the meeting of Member States on programmes and priority setting (see Annex).

ANNEX

WHO REFORM: MEETING OF MEMBER STATES ON PROGRAMMES AND PRIORITY SETTING

Chairman’s report

1. As mandated by decision EB130(6), the meeting of Member States on programmes and priority setting was held from 27 to 28 February 2012 in Geneva and was chaired by Mr Rahhal El Makkaoui, Executive Board Chairman. The meeting was attended by 92 Member States and one regional economic integration organization. The meeting was preceded by a briefing by the Secretariat on 26 February on current priority-setting practices and strengths and weaknesses of those practices; and on the relationship between the country cooperation strategies, the general programme of work formulation process, and the programme and budgeting process.

2. The meeting reached consensus on the following: criteria, categories, and timeline. The agreed texts are appended. An exchange of views was held on methodology.

3. In addition, the meeting provided the following guidance to the Secretariat as it proceeds to develop the next general programme of work and programme budget: the Secretariat should apply the agreed-upon criteria and categories, use the six core functions defined in the Eleventh General Programme of Work, 2006-2015, adjusting them if necessary to address new realities, and suggest priorities in the draft outline for the Twelfth General Programme of Work and Programme Budget. It was also agreed that a sixth area covering corporate services should be reflected in the General Programme of Work and Programme Budget. Additionally, the Secretariat should use the new results chain agreed upon at the special session of the Executive Board on WHO reform held in November 2011 in the preparation of the draft outline of the Twelfth General Programme of Work and the draft Proposed programme budget 2014-2015. In developing the programme budget, the Secretariat should give full information on which programmes, actions and results WHO should pursue under the respective new categories and also on the amounts and reasoning behind. This could be done in a technical document. The Secretariat should also learn from the experience of other international organizations and ensure that the priorities are set by the WHO governing bodies and not by donors.

4. It was also agreed that the criteria, the categories and the priorities identified should be used to streamline the resolutions and decisions of the WHO governing bodies.

5. The Director-General is requested to transmit this report to the Sixty-fifth World Health Assembly.
Appendix 1

CRITERIA FOR PRIORITY SETTING AND PROGRAMMES IN WHO

The priorities of WHO should be aligned with its Constitution, particularly the principles of the preamble and the objective of the Organization of the attainment by all peoples of the highest possible level of health, and the functions for achieving that objective as contained in Article 2 of the Constitution. This includes the mandate “to act as the directing and co-ordinating authority on international health work”, giving due emphasis to countries and populations in greatest need, and taking into account gender equality, universal coverage, as well as the economic, social and environmental determinants of health. (agreed)

The specific criteria are:

1. **The current health situation** including: demographic and epidemiological trends and changes, urgent, emerging and neglected health issues; taking into account the burden of disease at the global, regional and/or country levels. (agreed)

2. **Needs of individual countries** for WHO support as articulated, where available, through the country cooperation strategy, as well as national health and development plans. (agreed)

3. **Internationally agreed instruments** which involve or have an impact on health such as declarations and agreements, as well as resolutions, decisions and other documents adopted by WHO’s governing bodies at the global and regional levels. (agreed)

4. The existence of **evidence-based, cost-effective interventions** and the potential for using knowledge, science and technology for improving health. (agreed)

5. **The comparative advantage of WHO**, including:
   a. capacity to develop evidence in response to current and emerging health issues;
   b. ability to contribute to capacity building;
   c. capacity to respond to changing needs based on ongoing assessment of performance;
   d. potential to work with other sectors, organizations, and stakeholders to have a significant impact on health. (agreed)

Appendix 2

CATEGORIES FOR PRIORITY SETTING AND PROGRAMMES IN WHO

1. **Communicable diseases**: reducing the burden of communicable diseases, including HIV/AIDS, tuberculosis, malaria, and neglected tropical diseases. (agreed)

2. **Noncommunicable diseases**: reducing the burden of noncommunicable diseases, including heart disease, cancer, lung disease, diabetes, and mental disorders as well as disability, and injuries, through health promotion and risk reduction, prevention, treatment and monitoring of noncommunicable diseases and their risk factors. (agreed)

3. **Promoting health through the life course**: reducing morbidity and mortality and improving health during pregnancy, childbirth, the neonatal period, childhood and adolescence; improving sexual and reproductive health; and promoting active and healthy ageing, taking into account the need to address determinants of health and internationally
agreed development goals, in particular the health-related Millennium Development Goals. *(agreed)*

4. **Health systems:** support the strengthening, organization with a focus on integrated service delivery and financing, of health systems with a particular focus on achieving universal coverage, strengthening human resources for health, health information systems, facilitating transfer of technologies, promoting access to affordable, quality, safe, and efficacious medical products, and promoting health services research. *(agreed)*

5. **Preparedness, surveillance and response:** surveillance and effective response to disease outbreaks, acute public health emergencies and the effective management of health-related aspects of humanitarian disasters to contribute to health security. *(agreed)*

**Appendix 3**

**ROADMAP AND TIMELINES**

27-28 February 2012: a meeting is held to advance the work of the Member State-driven process on methods for programmes and priority setting.

May 2012: the draft outline of the Twelfth General Programme of Work 2014-2019 is submitted for review and discussion to the Programme, Budget and Administration Committee at its sixteenth meeting and the Sixty-fifth World Health Assembly.

End August - mid-October 2012: the regional committees review the draft Twelfth General Programme of Work 2014-2019 and the draft Proposed programme budget 2014-2015. Input from Member States informs further development of these documents.

Mid-August - mid-October 2012: a web consultation is held on the draft Twelfth General Programme of Work 2014-2019 to solicit input and comments from a wider group of stakeholders.

End November/early December 2012: if the Executive Board approves the change in timing, the Programme, Budget and Administration Committee at its seventeenth meeting could review the revised draft Twelfth General Programme of Work 2014-2019 following review by the regional committees and the web consultation; and the revised draft Proposed programme budget 2014-2015 incorporating input from the regional committees.


May 2013: the draft Twelfth General Programme of Work 2014-2019 and draft Proposed programme budget 2014-2015, incorporating comments from the Executive Board, are submitted to the Sixty-sixth World Health Assembly through the Programme, Budget and Administration Committee at its eighteenth meeting.
Annex 1. Structure of WHO

Six Regional Offices

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Indonesia
Maldives
Myanmar
Nepal
Sri Lanka
Thailand
Timor-Leste

Regional Office for Africa (AFRO):
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Tel: +242 770 0202 /
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Algeria
Angola
Benin
Botswana
Burkina Faso
Burundi
Cameroon
Cape Verde
Central African Republic
Chad
Comoros
Congo
Côte d’Ivoire
Democratic Republic of the Congo
Equatorial Guinea
Eritrea
Ethiopia
Gabon
Gambia
Ghana
Guinea
Guinée-Bissau
Kenya
Lesotho
Liberia
Madagascar
Malawi
Mali
Mauritania
Mauritius
Mozambique
Namibia
Niger
Nigeria
Rwanda
Sao Tome and Principe
Senegal
Seychelles
Sierra Leone
South Africa
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<td>Regional Office for Europe (EURO):</td>
<td>Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkmenistan, Ukraine, United Kingdom, Uzbekistan</td>
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