RESOLUTIONS

WHA62.1 Prevention of avoidable blindness and visual impairment[1]

The Sixty-second World Health Assembly,

Having considered the report and draft action plan on the prevention of avoidable blindness and visual impairment;[2]

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

Recognizing that the action plan for the prevention of avoidable blindness and visual impairment complements the action plan for the global strategy for the prevention and control of noncommunicable diseases endorsed by the Health Assembly in resolution WHA61.14,

1. ENDORSES the action plan for the prevention of avoidable blindness and visual impairment;[3]

2. URGES Member States to implement the action plan for the prevention of avoidable blindness and visual impairment, in accordance with national priorities for health policies, plans and programmes;

3. REQUESTS the Director-General:

(1) to provide support to Member States in implementing the proposed actions in the plan for the prevention of avoidable blindness and visual impairment in accordance with national priorities;

(2) to continue to give priority to the prevention of avoidable blindness and visual impairment, within the framework of the Medium-term strategic plan 2008–2013 and the programme budgets in order to strengthen capacity of the Member States and increase technical capacity of the Secretariat;

(3) to report to the Sixty-fifth and Sixty-seventh World Health Assemblies, through the Executive Board, on progress in implementing the action plan for the prevention of avoidable blindness and visual impairment.

(Sixth plenary meeting, 21 May 2009 –
Committee A, first report)

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[1] See Annex 5 for the financial and administrative implications for the Secretariat of the resolution.

[2] Document A62/7.

[3] See Annex 1.

WHA62.2 Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan[1]

The Sixty-second World Health Assembly,

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

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

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

Taking note of the report of the Director-General on the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan;[2]

Noting with deep concern the findings in the report of the Director-General on the specialized health mission to the Gaza Strip;[3]

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

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

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

Affirming the need for guaranteeing universal coverage of health services and for preserving the functions of the public health services in the occupied Palestinian territory;

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

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

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

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[1] See Annex 5 for the financial and administrative implications for the Secretariat of the resolution.

[2] Documents A62/24 and A62/24 Corr.1.

[3] Document A62/24 Add.1.

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

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

1. DEMANDS that Israel, the occupying power:

(1) lift immediately the closure in the occupied Palestinian territory, particularly the closure of the crossing points of the occupied Gaza Strip that are causing the serious shortage of medicines and medical supplies therein, and comply in this regard with the provisions of the Israeli Palestinian Agreement on Movement and Access of November 2005;

(2) reverse its policies and measures that have led to the prevailing dire health conditions and severe food and fuel shortages in the Gaza Strip;

(3) comply with the Advisory Opinion rendered on 9 July 2004 by the International Court of Justice on the wall which, inter alia, has grave implications on the accessibility and quality of medical services received by the Palestinian population in the occupied Palestinian territory, including east Jerusalem;

(4) facilitate the access of Palestinian patients and medical staff to the Palestinian health institutions in occupied east Jerusalem and abroad;

(5) ensure unhindered and safe passage for Palestinian ambulances as well as respect and protection of medical personnel, in compliance with international humanitarian law;

(6) improve the living and medical conditions of Palestinian detainees, particularly children, women and patients;

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

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

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

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

2. URGES Member States and intergovernmental and nongovernmental organizations:

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

(2) to help meet the urgent health and humanitarian needs, as well as the important health-related needs for the medium and long term, identified in the report of the Director-General on the specialized health mission to the Gaza Strip;[1]

(3) to help lift the restrictions and obstacles imposed on the Palestinian people in the occupied Palestinian territory;

(4) to remind Israel, the occupying power, to abide by the Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War of 1949;

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

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

3. EXPRESSES its deep appreciation to the Director-General for the efforts to provide necessary assistance to the Palestinian people in the occupied Palestinian territory, including east Jerusalem, and to the Syrian population in the occupied Syrian Golan;

4. REQUESTS the Director-General:

(1) to provide support to the Palestinian health and veterinary services including capacity building;

(2) to submit a fact-finding report on the health and economic situation in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan;

(3) to support the establishment of medical facilities and provide health-related technical assistance for the Syrian population in the occupied Syrian Golan;

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

(5) to provide also support to the Palestinian health and veterinary services in preparing for a potential pandemic of influenza A(H1N1);

(6) to support the development of the health system in Palestine, including development of human resources;

(7) to make available the detailed report prepared by the specialized health mission to the Gaza Strip;

(8) to report on implementation of this resolution to the Sixty-third World Health Assembly.

(Seventh plenary meeting, 21 May 2009 –
Committee B, first report)

[1] Document A62/24 Add.1.

WHA62.3 Unaudited interim financial report on the accounts of WHO for 2008

The Sixty-second World Health Assembly,

Having examined the unaudited interim financial report for 2008;[1]

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

ACCEPTS the Director-General's unaudited interim financial report for the year 2008.

(Seventh plenary meeting, 21 May 2009 –
Committee B, first report)

WHA62.4 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution

The Sixty-second World Health Assembly,

Having considered the fifth report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-second World Health Assembly on Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution;[3]

Noting that, at the time of opening of the Sixty-second World Health Assembly, the voting rights of Argentina, Central African Republic, Comoros, Democratic Republic of the Congo, Dominica, Gambia, Guinea-Bissau, Solomon Islands, Somalia and Tajikistan were suspended, such suspension to continue until the arrears of the Member States concerned have been reduced, at the present or future Health Assemblies, to a level below the amount that would justify invoking Article 7 of the Constitution;

Noting that Cape Verde, Côte d'Ivoire, Marshall Islands, Palau and Zambia were in arrears at the time of the opening of the Sixty-second World Health Assembly to such an extent that it was necessary for the Health Assembly to consider, in accordance with Article 7 of the Constitution, whether or not the voting privileges of those countries should be suspended at the opening of the Sixty-third World Health Assembly,

DECIDES:

(1) that in accordance with the statement of principles set out in resolution WHA41.7 if, by the time of the opening of the Sixty-third World Health Assembly, Cape Verde, Côte d'Ivoire, Marshall Islands, Palau and Zambia are still in arrears in the payment of their contributions to

[1] See documents A62/28 and A62/28 Corr.1.

[2] See document A62/44.

[3] See document A62/47.

an extent that would justify invoking Article 7 of the Constitution, their voting privileges shall be suspended as from the said opening;

(2) that any suspension that takes effect as specified in paragraph (1) shall continue at subsequent Health Assemblies, until the arrears of Cape Verde, Côte d'Ivoire, Marshall Islands, Palau and Zambia have been reduced to a level below the amount that would justify invoking Article 7 of the Constitution;

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

(Seventh plenary meeting, 21 May 2009 –
Committee B, first report)

WHA62.5 Scale of assessments 2010–2011

The Sixty-second World Health Assembly,

Considering that the latest United Nations scale continues to be the same as that for the financial period 2008–2009,

ADOPTS the scale of assessments for Members for the biennium 2010–2011 as set out below:

Members and Associate Members	WHO scale for 2010–2011 %
Afghanistan	0.0010
Albania	0.0060
Algeria	0.0850
Andorra	0.0080
Angola	0.0030
Antigua and Barbuda	0.0020
Argentina	0.3250
Armenia	0.0020
Australia	1.7871
Austria	0.8871
Azerbaijan	0.0050
Bahamas	0.0160
Bahrain	0.0330
Bangladesh	0.0100
Barbados	0.0090
Belarus	0.0200
Belgium	1.1021
Belize	0.0010
Benin	0.0010
Bhutan	0.0010
Bolivia (Plurinational State of)	0.0060
Bosnia and Herzegovina	0.0060
Botswana	0.0140

Members and Associate Members	WHO scale for 2010–2011 %
Brazil	0.8761
Brunei Darussalam	0.0260
Bulgaria	0.0200
Burkina Faso	0.0020
Burundi	0.0010
Cambodia	0.0010
Cameroon	0.0090
Canada	2.9772
Cape Verde	0.0010
Central African Republic	0.0010
Chad	0.0010
Chile	0.1610
China	2.6672
Colombia	0.1050
Comoros	0.0010
Congo	0.0010
Cook Islands	0.0010
Costa Rica	0.0320
Côte d'Ivoire	0.0090
Croatia	0.0500
Cuba	0.0540
Cyprus	0.0440
Czech Republic	0.2810
Democratic People's Republic of Korea	0.0070
Democratic Republic of the Congo	0.0030
Denmark	0.7391
Djibouti	0.0010
Dominica	0.0010
Dominican Republic	0.0240
Ecuador	0.0210
Egypt	0.0880
El Salvador	0.0200
Equatorial Guinea	0.0020
Eritrea	0.0010
Estonia	0.0160
Ethiopia	0.0030
Fiji	0.0030
Finland	0.5640
France	6.3015
Gabon	0.0080
Gambia	0.0010
Georgia	0.0030
Germany	8.5777
Ghana	0.0040
Greece	0.5960
Grenada	0.0010

Members and Associate Members	WHO scale for 2010–2011 %
Guatemala	0.0320
Guinea	0.0010
Guinea-Bissau	0.0010
Guyana	0.0010
Haiti	0.0020
Honduras	0.0050
Hungary	0.2440
Iceland	0.0370
India	0.4500
Indonesia	0.1610
Iran (Islamic Republic of)	0.1800
Iraq	0.0150
Ireland	0.4450
Israel	0.4190
Italy	5.0794
Jamaica	0.0100
Japan	16.6253
Jordan	0.0120
Kazakhstan	0.0290
Kenya	0.0100
Kiribati	0.0010
Kuwait	0.1820
Kyrgyzstan	0.0010
Lao People's Democratic Republic	0.0010
Latvia	0.0180
Lebanon	0.0340
Lesotho	0.0010
Liberia	0.0010
Libyan Arab Jamahiriya	0.0620
Lithuania	0.0310
Luxembourg	0.0850
Madagascar	0.0020
Malawi	0.0010
Malaysia	0.1900
Maldives	0.0010
Mali	0.0010
Malta	0.0170
Marshall Islands	0.0010
Mauritania	0.0010
Mauritius	0.0110
Mexico	2.2572
Micronesia (Federated States of)	0.0010
Monaco	0.0030
Mongolia	0.0010
Montenegro	0.0010
Morocco	0.0420
Mozambique	0.0010

Members and Associate Members	WHO scale for 2010–2011 %
Myanmar	0.0050
Namibia	0.0060
Nauru	0.0010
Nepal	0.0030
Netherlands	1.8731
New Zealand	0.2560
Nicaragua	0.0020
Niger	0.0010
Nigeria	0.0480
Niue	0.0010
Norway	0.7821
Oman	0.0730
Pakistan	0.0590
Palau	0.0010
Panama	0.0230
Papua New Guinea	0.0020
Paraguay	0.0050
Peru	0.0780
Philippines	0.0780
Poland	0.5010
Portugal	0.5270
Puerto Rico	0.0010
Qatar	0.0850
Republic of Korea	2.1732
Republic of Moldova	0.0010
Romania	0.0700
Russian Federation	1.2001
Rwanda	0.0010
Saint Kitts and Nevis	0.0010
Saint Lucia	0.0010
Saint Vincent and the Grenadines	0.0010
Samoa	0.0010
San Marino	0.0030
Sao Tome and Principe	0.0010
Saudi Arabia	0.7481
Senegal	0.0040
Serbia	0.0210
Seychelles	0.0020
Sierra Leone	0.0010
Singapore	0.3470
Slovakia	0.0630
Slovenia	0.0960
Solomon Islands	0.0010
Somalia	0.0010
South Africa	0.2900
Spain	2.9682
Sri Lanka	0.0160

Members and Associate Members	WHO scale for 2010–2011 %
Sudan	0.0100
Suriname	0.0010
Swaziland	0.0020
Sweden	1.0711
Switzerland	1.2161
Syrian Arab Republic	0.0160
Tajikistan	0.0010
Thailand	0.1860
The former Yugoslav Republic of Macedonia	0.0050
Timor-Leste	0.0010
Togo	0.0010
Tokelau	0.0010
Tonga	0.0010
Trinidad and Tobago	0.0270
Tunisia	0.0310
Turkey	0.3810
Turkmenistan	0.0060
Tuvalu	0.0010
Uganda	0.0030
Ukraine	0.0450
United Arab Emirates	0.3020
United Kingdom of Great Britain and Northern Ireland	6.6425
United Republic of Tanzania	0.0060
United States of America	22.0000
Uruguay	0.0270
Uzbekistan	0.0080
Vanuatu	0.0010
Venezuela (Bolivarian Republic of)	0.2000
Viet Nam	0.0240
Yemen	0.0070
Zambia	0.0010
Zimbabwe	0.0080
Total	100.0000

(Seventh plenary meeting, 21 May 2009 – Committee B, first report)

WHA62.6 Amendments to the Financial Regulations and Financial Rules[1]

The Sixty-second World Health Assembly,

Having considered the report on amendments to the Financial Regulations and Financial Rules,[2]

Recalling resolution WHA60.9 on amendments to the Financial Regulations and Financial Rules: introduction of International Public Sector Accounting Standards,

1. ADOPTS the amendments to the Financial Regulations, to be effective as from 1 January 2010;

2. NOTES that the changes to the Financial Rules as confirmed by the Executive Board at its 124th session[3] shall be effective at the same time as the amendments to the Financial Regulations adopted in paragraph 1;

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

(Seventh plenary meeting, 21 May 2009 –
Committee B, first report)

WHA62.7 Amendments to Staff Regulations[4]

The Sixty-second World Health Assembly,

Noting the recommendations of the Executive Board with regard to the reassignment of staff, including those not involving promotion,[5]

ADOPTS the proposed amendment to Staff Regulation 4.2;

ADOPTS the proposed amendment to Staff Regulation 4.3;

DECIDES that both amendments shall take effect on 1 June 2009.

(Seventh plenary meeting, 21 May 2009 –
Committee B, first report)

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[1] See Annex 2.

[2] Document A62/32.

[3] Resolution EB124.R10.

[4] See Annex 3.

[5] Document A62/36.

WHA62.8 Salaries of staff in ungraded posts and of the Director-General

The Sixty-second World Health Assembly,

Noting the recommendations of the Executive Board with regard to remuneration of staff in ungraded posts and of the Director-General,[1]

1. ESTABLISHES the salaries of Assistant Directors-General and Regional Directors at US$ 177 032 per annum before staff assessment, resulting in a modified net salary of US$ 128 071 (dependency rate) or US$ 115 973 (single rate);

2. ESTABLISHES the salary of the Deputy Director-General at US$ 194 820 per annum before staff assessment, resulting in a modified net salary of US$ 139 633 (dependency rate) or US$ 125 663 (single rate);

3. ESTABLISHES the salary of the Director-General at US$ 239 632 gross per annum before staff assessment, resulting in a modified net salary of US$ 168 761 (dependency rate) or US$ 150 079 (single rate);

4. DECIDES that those adjustments in remuneration shall take effect on 1 January 2009.

(Seventh plenary meeting, 21 May 2009 –
Committee B, first report)

WHA62.9 Appropriation resolution for the financial period 2010–2011

The Sixty-second World Health Assembly,

1. NOTES the total effective budget under all sources of funds, that is, assessed and voluntary contributions, of US$ 4 539 914 000, presented in three segments:

Programme budget segment	**US$**
Base programmes	3 367 907 000
Special programmes and collaborative arrangements	822 007 000
Outbreak and crisis response	350 000 000
Total effective budget	**4 539 914 000**

2. RESOLVES to appropriate for the financial period 2010–2011 an amount of US$ 1 023 840 000, financed by net assessments on Members of US$ 928 840 000, estimated Miscellaneous Income[2] of US$ 15 000 000, and transfer to Tax Equalization Fund of US$ 80 000 000, as shown below:

[1] Document A62/36.

[2] Miscellaneous Income is replaced by "Other Sources" in revisions to the Financial Regulations that will become effective on 1 January 2010, as a result of adoption of resolution WHA62.6.

Appropriation section	Purpose of appropriation	Appropriations financed by net assessments and Miscellaneous Income (US$)
1	To reduce the health, social and economic burden of communicable diseases	74 035 000
2	To combat HIV/AIDS, malaria and tuberculosis	40 762 000
3	To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment	38 038 000
4	To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals	46 497 000
5	To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	16 090 000
6	To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex	31 368 000
7	To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	15 456 000
8	To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	30 198 000
9	To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development	18 748 000
10	To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research	130 799 000
11	To ensure improved access, quality and use of medical products and technologies	27 631 000

Appropriation section	Purpose of appropriation	Appropriations financed by net assessments and Miscellaneous Income (US$)
12	To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work	179 551 000
13	To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	294 667 000
	Subtotal	943 840 000
	Transfer to Tax Equalization Fund	80 000 000
	Grand total	1 023 840 000

3. FURTHER RESOLVES that:

(1) notwithstanding the provisions of Financial Regulation 4.3, the Director-General is authorized to make transfers between the appropriation sections up to an amount not exceeding 10% of the amount appropriated for the section from which the transfer is made; all such transfers shall be reported in the financial report for the financial period 2010–2011; any other transfers required shall be made and reported in accordance with the provisions of Financial Regulation 4.3;

(2) amounts not exceeding the appropriations voted under paragraph 2 shall be available for the payment of commitments incurred during the financial period 1 January 2010 to 31 December 2011 in accordance with the provisions of the Financial Regulations; notwithstanding the provisions of the present paragraph, the Director-General shall limit the commitments to be incurred during the financial period 2010–2011 to sections 1 to 13;

(3) the amount of the contribution to be paid by individual Members shall be reduced by the sum standing to their credit in the Tax Equalization Fund; that reduction shall be adjusted in the case of those Members that require staff members to pay income taxes on their WHO emoluments, taxes which the Organization reimburses to said staff members; the amount of such tax reimbursements is estimated at US$ 16 274 400, resulting in a total assessment on Members of US$ 945 114 400;

4. DECIDES that the Working Capital Fund shall be maintained at its existing level of US$ 31 000 000.

5. NOTES that the voluntary contributions required to meet the portion of the effective working budget not financed through net assessments on Members is US$ 3 596 074 000.

(Eighth plenary meeting, 22 May 2009 –
Committee A, first report)

WHA62.10 Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits

The Sixty-second World Health Assembly,

Having considered the reports on pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits;[1]

Recalling resolution WHA60.28 on pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits, which requested the Director-General to convene an intergovernmental meeting;

Recognizing that the Intergovernmental Meeting reached agreement on most elements of the Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits;[2]

Reaffirming the need for long-term solutions for pandemic influenza preparedness and response;

Recognizing also that further work needs to be done on some key remaining elements of the Pandemic Influenza Preparedness Framework,

REQUESTS the Director-General:

(1) to work with Member States to take forward the agreed parts of the Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits as contained in the report of the outcome of the Intergovernmental Meeting;[3]

(2) to facilitate a transparent process to finalize the remaining elements, including the Standard Material Transfer Agreements and its annex, and report the outcome to the Executive Board at its 126th session in January 2010.

(Eighth plenary meeting, 22 May 2009 –
Committee A, second report)

WHA62.11 Medium-term strategic plan 2008–2013, including Programme budget 2010–2011

The Sixty-second World Health Assembly,

Recalling resolution WHA60.11 on the Medium-term strategic plan 2008–2013;

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[1] Documents A62/5 and A62/5 Add.1.

[2] Document A62/5 Add.1, Annex.

[3] Document A62/5 Add.1, Appendix.

Having considered the report on the Medium-term strategic plan 2008–2013, including Proposed programme budget 2010–2011;[1]

Having examined the draft amended Medium-term strategic plan 2008–2013,[2]

ENDORSES the amended Medium-term strategic plan 2008–2013, including its revised indicators and targets.

(Eighth plenary meeting, 22 May 2009 –
Committee A, third report)

WHA62.12 Primary health care, including health system strengthening[3]

The Sixty-second World Health Assembly,

Welcoming the efforts of the Director-General, and recognizing the pivotal role that WHO plays, in promoting primary health care globally;

Having considered the report on primary health care, including health system strengthening;[4]

Reaffirming the Declaration of Alma-Ata (1978) and the United Nations Millennium Declaration (2000);

Recalling the Ottawa Charter for Health Promotion (1986) and subsequent relevant resolutions of WHO regional committees and Health Assemblies;[5]

Recalling also the discussions at the series of summits and global, regional and national conferences that have reaffirmed the commitment of Member States to primary health care and strengthening health systems;[6]

Noting the growing consensus in the global health community that vertical approaches, such as disease-specific programmes, and integrated health systems approaches are mutually reinforcing and contribute to achieving the health-related Millennium Development Goals;

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[1] Document A62/4.

[2] See documents MTSP/2008–2013 (Amended (draft)) and PPB/2010–2011.

[3] See Annex 5 for the financial and administrative implications for the Secretariat of the resolution.

[4] Document A62/8.

[5] Resolutions WHA54.13, WHA56.6, WHA57.19, WHA58.17, WHA58.33, WHA60.22, WHA60.24, WHA60.27, WHA61.17 and WHA61.18.

[6] Including summits on health system strengthening, such as the G8 Hokkaido Toyako Summit (2008), International Conference on Global Action for Health System Strengthening (Tokyo, 2008), International Conference dedicated to the 30th Anniversary of the Alma-Ata Declaration of WHO/UNICEF on primary health care (Almaty, 2008), and G15 Summit (2004); WHO regional meetings on primary health care, such as those at Buenos Aires (2007), Beijing (2007), Bangkok (2008), Tallinn (2008), Ouagadougou (2008), Jakarta (2008) and Doha (2008); and conferences on health promotion, such as Ottawa (1986), Adelaide (1988), Sundsvall (1991), Jakarta (1997), Mexico City (2000), Bangkok (2005) and the MERCOSUR Task Force on Health (since 1995).

Recognizing the need to draw on the experiences, both positive and negative, of primary health care in the years since the Declaration of Alma-Ata and the Millennium Declaration;

Welcoming *The world health report 2008*,[1] published on the thirtieth anniversary of the international conference of Alma-Ata, that identifies four broad policy directions for reducing health inequalities and improving health for all: tackling health inequalities through universal coverage, putting people at the centre of care, integrating health into broader public policy, and providing inclusive leadership for health; and also welcoming the final report of the Commission on Social Determinants of Health;[2]

Reaffirming the need to build sustainable national health systems, strengthen national capacities, and honour fully financing commitments made by national governments and their development partners, as appropriate, in order to better fill the resource gaps in the health sector;

Reaffirming also the need to take concrete, effective and timely action, in implementing all agreed commitments on aid effectiveness and to increase the predictability of aid, while respecting recipient countries' control and ownership of their health system strengthening, all the more so given the potential effects on health and health systems of the current international financial and food crises and of climate change;

Strongly reaffirming the values and principles of primary health care, including equity, solidarity, social justice, universal access to services, multisectoral action, decentralization and community participation as the basis for strengthening health systems,

1. URGES Member States:

(1) to ensure political commitment at all levels to the values and principles of the Declaration of Alma-Ata, keep the issue of strengthening health systems based on the primary health care approach high on the international political agenda, and take advantage, as appropriate, of health-related partnerships and initiatives relating to this issue, particularly to support achievement of the health-related Millennium Development Goals;

(2) to accelerate action towards universal access to primary health care by developing comprehensive health services and by developing national equitable, efficient and sustainable financing mechanisms, mindful of the need to ensure social protection and protect health budgets in the context of the current international financial crisis;

(3) to put people at the centre of health care by adopting, as appropriate, delivery models focused on the local and district levels that provide comprehensive primary health care services, including health promotion, disease prevention, curative care and palliative care, that are integrated with other levels of care and coordinated according to need, while ensuring effective referral to secondary and tertiary care;

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[1] *The world health report 2008: Primary health care – now more than ever.* Geneva, World Heath Organization, 2008.

[2] Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health.* Geneva, World Health Organization, 2008.

(4) to promote active participation by all people, and re-emphasize the empowering of communities, especially women, in the processes of developing and implementing policy and improving health and health care, in order to support the renewal of primary health care;

(5) to train and retain adequate numbers of health workers, with appropriate skill mix, including primary care nurses, midwives, allied health professionals and family physicians, able to work in a multidisciplinary context, in cooperation with non-professional community health workers in order to respond effectively to people's health needs;

(6) to encourage the development, integration and implementation of vertical programmes, including disease-specific programmes, in the context of integrated primary health care;

(7) to improve access to appropriate medicines, health products and technologies, all of which are required to support primary health care;

(8) to develop and strengthen health information and surveillance systems, relating to primary health care in order to facilitate evidence-based policies and programmes and their evaluation;

(9) to strengthen health ministries, enabling them to provide inclusive, transparent and accountable leadership of the health sector and to facilitate multisectoral action as part of primary health care;

2. REQUESTS the Director-General:

(1) to ensure that WHO reflects the values and principles of the Declaration of Alma-Ata in its work and that the overall organizational efforts across all levels contribute to the renewal and strengthening of primary health care, in accordance with the findings of the Commission on Social Determinants of Health;

(2) to strengthen the Secretariat's capacities, including those of regional and country offices, to support Member States' efforts to deliver on the four broad policy directions for renewal and strengthening of primary health care identified in *The world health report 2008*;

(3) to collate and analyse past and current experiences of Member States in implementing primary health care and facilitate the exchange of experience, evidence and information on good practice in achieving universal coverage and strengthening health systems;

(4) to foster alignment and coordination of global interventions for health system strengthening, basing them on the primary health care approach, in collaboration with Member States, relevant international organizations, international health initiatives, and other stakeholders in order to increase synergies between international and national priorities;

(5) to ensure adequate funding for health system strengthening and revitalizing primary health care in the Programme budget 2010–2011;

(6) to prepare implementation plans for the four broad policy directions: (a) dealing with inequalities by moving towards universal coverage; (b) putting people at the centre of service delivery; (c) multisectoral action and health in all policies; (d) inclusive leadership and effective governance for health; to ensure that these plans span the work of the entire Organization, and

to report on these plans through the Executive Board to the Sixty-third World Health Assembly and subsequently on progress every two years thereafter.

(Eighth plenary meeting, 22 May 2009 –
Committee A, third report)

WHA62.13 Traditional medicine

The Sixty-second World Health Assembly,

Having considered the report on primary health care, including health system strengthening;[1]

Recalling resolutions WHA22.54, WHA29.72, WHA30.49, WHA31.33, WHA40.33, WHA41.19, WHA42.43, WHA54.11, WHA56.31 and WHA61.21;

Recalling the Declaration of Alma-Ata which states, inter alia, that "The people have the right and duty to participate individually and collectively in the planning and implementation of their health care" and "Primary health care relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community";

Noting that the term "traditional medicine" covers a wide variety of therapies and practices, which may vary greatly from country to country and from region to region;

Recognizing traditional medicine as one of the resources of primary health care services that could contribute to improved health outcomes, including those in the Millennium Development Goals;

Recognizing that Member States have different domestic legislation, approaches, regulatory responsibilities and delivery models related to primary health care;

Noting the progress that many governments have made to include traditional medicine into their national health systems;

Noting that progress in the field of traditional medicine has been achieved by a number of Member States through implementation of WHO's traditional medicine strategy 2002–2005;[2]

Expressing the need for action and cooperation by the international community, governments, and health professionals and workers, to ensure proper use of traditional medicine as an important component contributing to the health of all people, in accordance with national capacity, priorities and relevant legislation;

Noting that the WHO Congress on Traditional Medicine took place from 7 to 9 November 2008, in Beijing, China, and adopted the Beijing Declaration on Traditional Medicine;

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[1] Document A62/8.

[2] Document WHO/EDM/TRM/2002.1.

Noting that African Traditional Medicine Day is commemorated annually on 31 August in order to raise awareness and the profile of traditional medicine in the African Region, as well as to promote its integration into national health systems,

1. URGES Member States, in accordance with national capacities, priorities, relevant legislation and circumstances:

(1) to consider adopting and implementing the Beijing Declaration on Traditional Medicine in accordance with national capacities, priorities, relevant legislation and circumstances;

(2) to respect, preserve and widely communicate, as appropriate, the knowledge of traditional medicine, treatments and practices, appropriately based on the circumstances in each country, and on evidence of safety, efficacy and quality;

(3) to formulate national policies, regulations and standards, as part of comprehensive national health systems, to promote appropriate, safe and effective use of traditional medicine;

(4) to consider, where appropriate, including traditional medicine into their national health systems based on national capacities, priorities, relevant legislation and circumstances, and on evidence of safety, efficacy and quality;

(5) to further develop traditional medicine based on research and innovation, giving due consideration to the specific actions related to traditional medicine in the implementation of the Global strategy and plan of action on public health, innovation and intellectual property;

(6) to consider, where appropriate, establishing systems for the qualification, accreditation or licensing of traditional medicine practitioners and to assist traditional medicine practitioners to upgrade their knowledge and skill in collaboration with relevant health providers, on the basis of traditions and customs of peoples and communities;

(7) to consider strengthening communication between conventional and traditional medicine providers and, where appropriate, establishing appropriate training programmes with content related to traditional medicine for health professionals, medical students and relevant researchers;

(8) to cooperate with each other in sharing knowledge and practices of traditional medicine and exchanging training programmes on traditional medicine, consistent with national legislation and relevant international obligations;

2. REQUESTS the Director-General:

(1) to provide support to Member States, as appropriate and upon request, in implementing the Beijing Declaration on Traditional Medicine;

(2) to update the WHO traditional medicine strategy 2002–2005, based on countries' progress and current new challenges in the field of traditional medicine;

(3) to give due consideration to the specific actions related to traditional medicine in the implementation of the Global strategy and plan of action on public health, innovation and intellectual property and the WHO global strategy for prevention and control of noncommunicable diseases;

(4) to continue providing policy guidance to countries on how to integrate traditional medicine into health systems, especially to promote, where appropriate, the use of traditional/indigenous medicine for primary health care, including disease prevention and health promotion, in line with evidence of safety, efficacy and quality, taking into account the traditions and customs of peoples and communities;

(5) to continue providing technical guidance to support countries in ensuring the safety, efficacy and quality of traditional medicine, considering the participation of peoples and communities and taking into account their traditions and customs;

(6) to strengthen cooperation with WHO collaborating centres, research institutions and nongovernmental organizations in order to share evidence-based information, taking into account the traditions and customs of peoples and communities; and to support training programmes for national capacity building in the field of traditional medicine.

(Eighth plenary meeting, 22 May 2009 –
Committee A, third report)

WHA62.14 Reducing health inequities through action on the social determinants of health

The Sixty-second World Health Assembly,

Having considered the report on the Commission on Social Determinants of Health;[1]

Noting 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;

Noting the sixtieth anniversary of the establishment of WHO in 1948, and its Constitution, which affirms 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;

Noting the thirtieth anniversary of the International Conference on Primary Health Care at Alma-Ata in 1978, which reaffirmed the essential value of equity in health and launched the global strategy of primary health care to achieve health for all;

Recalling the principles of "Health for All", notably the need for intersectoral action (resolution WHA30.43);

Confirming the importance of addressing the wider determinants of health and considering the actions and recommendations set out in the series of international health promotion conferences, from the Ottawa Charter on Health Promotion to the Bangkok Charter for Health Promotion in a Globalized World, making the promotion of health central to the global development agenda as a core responsibility of all governments (resolution WHA60.24);

[1] Document A62/9.

Noting the global consensus of the United Nations Millennium Declaration to achieve the Millennium Development Goals by 2015 and the concern at the lack of sufficient progress towards many of these goals in some regions at the half-way point;

Welcoming in this regard resolution WHA61.18, which initiates annual monitoring by the Health Assembly of the achievement of health-related Millennium Development Goals;

Noting *The world health report 2008*[1] on primary health care and its focus on ways to improve health equity by reforming health and other societal systems;

Mindful about the fact that responses to environmental degradation and climate change include health equity issues and noting that the impact of climate change is expected to affect negatively the health of vulnerable and disadvantaged populations (resolution WHA61.19);

Mindful about the facts concerning widening gaps in life expectancy worldwide;

Attaching utmost importance to the elimination of gender-related health inequities;

Recognizing that millions of children globally are not reaching their full potential and that investing in comprehensive supports for early child development that are accessible to all children is a fundamental step in achieving health equity across the lifespan;

Acknowledging that improvement of unfavourable social conditions is primarily a social policy issue;

Noting the need to improve coordination among global, national and subnational efforts in tackling social determinants of health through work across sectors, while simultaneously promoting social and economic development, with the understanding that such action requires the collaboration of many partners, including civil society and private sector;

Mindful of the important role of existing global governance[2] mechanisms to support Member States in provision of basic services essential to health and the regulation of goods and services with a major impact on health, and the need for corporate responsibility,

1. EXPRESSES its appreciation for the work done by the Commission on Social Determinants of Health;

2. CALLS UPON the international community, including United Nations agencies, intergovernmental bodies, civil society and the private sector:

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[1] *The world health report 2008: primary health care – now more than ever.* Geneva, World Health Organization, 2008.

[2] See WHO web site: http://www.who.int/trade/glossary/story038/en, accessed 18 June 2009.

(1) to take note of the final report of the Commission on Social Determinants of Health and its recommendations;[1]

(2) to take action in collaboration with WHO's Member States and the WHO Secretariat on assessing the impacts of policies and programmes on health inequities and on addressing the social determinants of health;

(3) to work closely with WHO's Member States and the WHO Secretariat on measures to enhance health equity in all policies in order to improve health for the entire population and reduce inequities;

(4) to consider health equity in working towards achievement of the core global development goals and to develop indicators to monitor progress, and to consider strengthening international collaboration in addressing the social determinants of health and in reducing health inequities;

3. URGES Member States:

(1) to tackle the health inequities within and across countries through political commitment on the main principles of "closing the gap in a generation" as a national concern, as is appropriate, and to coordinate and manage intersectoral action for health in order to mainstream health equity in all policies, where appropriate, by using health and health equity impact assessment tools;

(2) to develop and implement goals and strategies to improve public health with a focus on health inequities;

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

(4) to ensure dialogue and cooperation among relevant sectors with the aim of integrating a consideration of health into relevant public policies and enhancing intersectoral action;

(5) to increase awareness among public and private health providers on how to take account of social determinants when delivering care to their patients;

(6) to contribute to the improvement of the daily living conditions contributing to health and social well-being across the lifespan by involving all relevant partners, including civil society and the private sector;

(7) to contribute to the empowerment of individuals and groups, especially those who are marginalized, and take steps to improve the societal conditions that affect their health;

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[1] Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health.* Geneva, World Health Organization, 2008.

(8) to generate new, or make use of existing, methods and evidence, tailored to national contexts in order to address the social determinants and social gradients of health and health inequities;

(9) to develop, make use of, and, if necessary, improve health information systems and research capacity in order to monitor and measure the health of national populations, with disaggregated data such as age, gender, ethnicity, race, caste, occupation, education, income and employment where national law and context permit so that health inequities can be detected and the impact of policies on health equity measured;

4. REQUESTS the Director-General:

(1) to work closely with partner agencies in the multilateral system on appropriate measures that address the social determinants of health and promote policy coherence in order to minimize health inequities; and to advocate inclusion of this topic high on global development and research agendas;

(2) to strengthen capacity within the Organization with the purpose of giving sufficient priority to relevant tasks related to addressing the social determinants of health in order to reduce health inequities;

(3) to make social determinants of health a guiding principle for the implementation of measures, including objective indicators for the monitoring of social determinants of health, across relevant areas of work and promote addressing social determinants of health to reduce health inequities as an objective of all areas of the Organization's work, especially priority public health programmes;

(4) to support the primary role of Member States in promoting access to basic services essential to health and the regulation, as appropriate, of goods and services with a major impact on health;

(5) to ensure that ongoing work on the revitalization of primary health care is aligned with work on addressing the social determinants of health, as recommended by *The world health report 2008*;

(6) to provide support to Member States in implementing a health-in-all-policies approach to tackling inequities in health;

(7) to provide support to Member States, upon request, in implementing measures with the aim of integrating a focus on social determinants of health across relevant sectors and in designing, or if necessary redesigning, their health sectors to address this appropriately;

(8) to provide support to Member States, upon request, in strengthening existing efforts on measurement and evaluation of the social determinants of health and the causes of health inequities and in developing and monitoring targets on health equity;

(9) to support research on effective policies and interventions to improve health by addressing the social determinants of health that also serve to strengthen research capacities and collaborations;

(10) to provide support to the regional directors in developing a regional focus on issues related to the social determinants of health and in engaging a broader range of countries in this issue, in accordance with the conditions and challenges of each region;

(11) to convene a global event, with the assistance of Member States, before the Sixty-fifth World Health Assembly in order to discuss renewed plans for addressing the alarming trends of health inequities through addressing social determinants of health;

(12) to assess the performance of existing global governance mechanisms to address the social determinants of health and reducing health inequities;

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

(Eighth plenary meeting, 22 May 2009 –
Committee A, third report)

WHA62.15 Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis[1]

The Sixty-second World Health Assembly,

Having considered the reports on the prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis;[2]

Noting the progress made since 1991 towards achieving the international targets for 2005, the acceleration of efforts following the establishment of the Stop TB Partnership in response to resolution WHA51.13, and more recently following resolution WHA58.14 encouraging Member States to ensure availability of sufficient resources to achieve the internationally agreed goal relevant to tuberculosis contained in the United Nations Millennium Declaration by 2015;

Aware that the development of the Stop TB strategy as a holistic approach to tuberculosis prevention and control represents a significant expansion in the scale and scope of tuberculosis-control activities as a part of strengthening health systems within the context of primary health care and addressing social determinants of health;

Noting that the Stop TB Partnership's Global Plan to Stop TB 2006–2015[3] sets out the activities oriented towards implementing the Stop TB strategy and achieving the international targets for tuberculosis control set by the Stop TB Partnership – in line with the target of the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration to "have halted by 2015 and begun to reverse the incidence of major diseases" – of halving tuberculosis prevalence and death rates by 2015 compared with 1990 levels;

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[1] See Annex 5 for the financial and administrative implications for the Secretariat of the resolution.

[2] Documents A62/20 and A62/20 Add.1.

[3] Document WHO/HTM/STB/2006.35.

Noting that the care and control of tuberculosis have progressed significantly during the past decade and the incidence of new cases is estimated to have fallen slightly each year since 2003;

Aware that a significant proportion – an estimated 37% of tuberculosis cases worldwide – remain un-notified and receive either no treatment or inappropriate treatment;

Recognizing that the rates of tuberculosis are disproportionately high in high-risk populations, including indigenous populations;

Recognizing that emergence and spread of multidrug-resistant and extensively drug-resistant tuberculosis are facilitated by not detecting sufficient cases of tuberculosis and not treating them appropriately by DOTS-based treatment;

Concerned that the highest levels of multidrug-resistance reported in WHO's fourth global report on anti-tuberculosis drug resistance[1] – an estimated half a million multidrug-resistant cases occurring globally, including 50 000 cases of extensively drug-resistant tuberculosis – pose a threat to global public health security;

Recognizing that there is an urgent need to invest in research for development of new diagnostics, medicines and vaccines and in operational research to prevent and manage tuberculosis, including multidrug-resistant and extensively drug-resistant tuberculosis, while exploring and, where appropriate, promoting a range of incentive schemes for research and development, including addressing, where appropriate, the de-linkage of the costs of research and development and the price of health products;

Noting that less than 3% of the estimated total number of cases of multidrug-resistant and extensively drug-resistant tuberculosis receive treatment according to WHO's recommended standards;

Concerned that the disease transmission occurs mostly in communities where there is a lack of appropriate infection control;

Concerned that the insufficient demand from countries for internationally quality-assured anti-tuberculosis medicines resulting in an inadequate supply through the Green Light Committee mechanism has been a major bottleneck to treating multidrug-resistant and extensively drug-resistant tuberculosis and that quality-assured fixed-dose drug combinations, developed as a tool to prevent the emergence of resistance, are not widely used;

Aware that the delays in implementing the Global Plan to Stop TB 2006–2015 will result in increasing numbers of tuberculosis cases and deaths, including those due to multidrug-resistant and extensively multidrug-resistant tuberculosis and to the impact of HIV, and therefore in delays in achieving by 2015 the international targets for tuberculosis control and the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;

Recalling resolution WHA60.19 on tuberculosis control in which the Health Assembly urged Member States to develop and implement long-term plans for tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis prevention and control in line with the Global

[1] Document WHO/HTM/TB/2008.394.

Plan to Stop TB 2006–2015 within the overall health development plans, and resolution WHA58.33 on achieving universal coverage;

Welcoming the Beijing Call for Action on tuberculosis control and patient care given jointly by representatives of 27 Member States carrying a high burden of multidrug-resistant and extensively drug-resistant tuberculosis, civil society, the private sector and others to address the alarming threat of multidrug-resistant and extensively drug-resistant tuberculosis,[1]

1. URGES all Member States:

(1) to achieve universal access to diagnosis and treatment of multidrug-resistant and extensively drug-resistant tuberculosis as part of the transition to universal health coverage, thereby saving lives and protecting communities, by means of:

(a) developing a comprehensive framework for management and care of multidrug-resistant and extensively drug-resistant tuberculosis that includes directly-observed treatment, community-based and patient-centred care, and which identifies and addresses the needs of persons living with HIV, the poor and other vulnerable groups, such as prisoners, mineworkers, migrants, drug users, and those dependent on alcohol, as well as the underlying social determinants of tuberculosis and multidrug-resistant and extensively drug-resistant tuberculosis;

(b) strengthening health information and surveillance systems to ensure detection and monitoring of the epidemiological profile of multidrug-resistant and extensively drug-resistant tuberculosis and monitor achievement in its prevention and control;

(c) aiming to ensure the removal of financial barriers to allow all tuberculosis patients equitable access to tuberculosis care, that their rights are protected, and that they are treated with respect and dignity in accordance with the local legislation;

(d) making available sufficiently trained and motivated staff in order to enable diagnosis, treatment and care of tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis, as an integral part of efforts to address the overall health workforce crisis;

(e) strengthening laboratory systems, through increasing capacity and adequate human resources, and accelerating access to faster and quality-assured diagnostic tests;

(f) engaging all relevant public and private health-care providers in managing tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis and tuberculosis-HIV coinfection according to national policies, and strengthening primary health care in early detection, effective treatment and support to patients;

(g) ensuring that national airborne infection-control policies are developed (as part of general infection prevention and control programmes) and implemented in every health-care facility and other high-risk settings and that there is sufficient awareness of tuberculosis infection control in the community;

[1] Document A62/20 Add.1, Annex.

(h) ensuring an uninterrupted supply of first- and second-line medicines for tuberculosis treatment, which meet WHO prequalification standards or strict national regulatory authority standards, and that quality-assured fixed-dose combination medicines of proven bioavailability are prioritized within a system that promotes treatment adherence;

(i) strengthening mechanisms to ensure that tuberculosis medicines are sold on prescription only and that they are prescribed and dispensed by accredited public and private providers;

(j) undertaking effective advocacy, communication and social mobilization, avoiding stigmatization and discrimination, and spreading community awareness about policies and plans for prevention and control of tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis;

(k) establishing national targets in order to accelerate access to treatment, according to WHO guidelines, for multidrug-resistant and extremely drug-resistant tuberculosis patients;

(2) to enhance quality and coverage of DOTS in achieving 70% detection rate and 85% success rate of tuberculosis treatment, thereby preventing secondary multidrug-resistant tuberculosis;

(3) to use all possible financing mechanisms in order to fulfil the commitments made in resolutions WHA58.14 and WHA60.19, including the commitment to ensure sustainable domestic and external financing, thereby filling the funding gaps identified in the Global Plan to Stop TB 2006–2015;

(4) to increase investment by countries and all partners substantially in operational research and research and development for new diagnostics, medicines and vaccines to prevent and manage tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis;

2. REQUESTS the Director-General:

(1) to provide technical support to Member States in order to develop and implement response plans, based on a comprehensive framework for management of care, for the prevention and control of tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis;

(2) to provide support to Member States in developing and implementing strategies to engage all relevant public, voluntary, corporate and private health-care providers in the training for and scaling up of prevention and control of tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis and all aspects of tuberculosis-HIV coinfection;

(3) to advise and support Member States in bringing the standards of national drug regulatory agencies into line with international standards, thus enabling national pharmaceutical manufacturers to produce material of assured quality to be sold in the local and international markets;

(4) to provide support to Member States for upgrading laboratory networks in order to have the capacity to diagnose and monitor multidrug-resistant and extensively drug-resistant tuberculosis and facilitate systematic evaluations of newer and faster diagnostic technology;

(5) to strengthen the Green Light Committee mechanism in order to help to expand access to concessionally-priced and quality-assured first- and second-line medicines through encouraging and assisting WHO prequalification of locally manufactured pharmaceuticals in high-burden countries;

(6) to explore and, where appropriate, promote a range of incentive schemes for research and development, including addressing, where appropriate, the de-linkage of the costs of research and development and the price of health products;

(7) to work with countries to develop country indicators and to support monitoring and evaluation of the implementation of the measures outlined in this resolution;

(8) to report through the Executive Board to the Sixty-third and Sixty-fifth World Health Assemblies on overall progress made.

(Eighth plenary meeting, 22 May 2009 –
Committee A, fourth report)

WHA62.16 Global strategy and plan of action on public health, innovation and intellectual property[1]

The Sixty-second World Health Assembly,

Recalling resolution WHA61.21 on the global strategy and plan of action on public health, innovation and intellectual property, and noting the information provided by the Secretariat;[2]

Welcoming the reference in the report by the Secretariat to the implementation of the African Network for Drugs and Diagnostics Innovations, which supports and promotes African-led health product innovation for the discovery, development and delivery of medicines and diagnostics for neglected tropical diseases, and reiterates the need to fast-track activities to reach neglected people who are sick and suffering from neglected tropical diseases,

1. DECIDES:

(1) to incorporate into the plan of action the additional agreed stakeholders as outlined in document A62/16 Add.3; deleting “interested” before “governments” for specific action 2.3(c);

(2) to incorporate into the plan of action the proposed time frames outlined in document A62/16 Add.1;

[1] See Annex 5 for the financial and administrative implications for the Secretariat of the resolution.

[2] Documents A62/16, A62/16 Add.1, A62/16 Add.2 and A62/16 Add.3.

2. ADOPTS the final plan of action, as amended in paragraph 1, in respect of specific actions, stakeholders and time frames;[1]

3. NOTES the estimated funding needs related to the plan of action;[2]

4. ACCEPTS the proposed progress indicators,[3] taking note of the need periodically to review and refine them; where the indicators are quantitative, the Secretariat shall provide complementary information on the implementation of the specific actions;

5. REQUESTS the Director-General to provide significantly increased support for greater efficiency and effectiveness in the implementation of the global strategy and plan of action on public health, innovation and intellectual property and prioritize concrete actions in the area of capacity-building and access;

6. FURTHER REQUESTS the Director-General, in addition to continued monitoring, to conduct an overall programme review of the global strategy and plan of action in 2014 on its achievements, remaining challenges and recommendations on the way forward to the Health Assembly in 2015 through the Executive Board.

(Eighth plenary meeting, 22 May 2009 –
Committee B, second report)

[1] See Annex 4.

[2] Document A62/16 Add.1.

[3] Document A62/16 Add.2.