EB140/2017/REC/1

WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD

140TH SESSION

GENEVA, 23–31 JANUARY 2017

RESOLUTIONS AND DECISIONS
ANNEXES

GENEVA
2017

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

ASEAN – Association of Southeast Asian Nations
FAO – Food and Agriculture Organization of the United Nations
IAEA – International Atomic Energy Agency
IARC – International Agency for Research on Cancer
ICAO – International Civil Aviation Organization
IFAD – International Fund for Agricultural Development
ILO – International Labour Organization (Office)
IMF – International Monetary Fund
IMO – International Maritime Organization
IOM – International Organization for Migration
INCB – International Narcotics Control Board
ITU – International Telecommunication Union
OECD – Organisation for Economic Co-operation and Development
OIE – World Organisation for Animal Health
PAHO – Pan American Health Organization
UNAIDS – Joint United Nations Programme on HIV/AIDS
UNCTAD – United Nations Conference on Trade and Development
UNODC – United Nations Office on Drugs and Crime
UNDP – United Nations Development Programme
UNEP – United Nations Environment Programme
UNESCO – United Nations Educational, Scientific and Cultural Organization
UNFPA – United Nations Population Fund
UNHCR – Office of the United Nations High Commissioner for Refugees
UNICEF – United Nations Children's Fund
UNIDO – United Nations Industrial Development Organization
UNRWA – United Nations Relief and Works Agency for Palestine Refugees in the Near East
WFP – World Food Programme
WIPO – World Intellectual Property Organization
WMO – World Meteorological Organization
WTO – World Trade Organization

PREFACE

The 140th session of the Executive Board was held at WHO headquarters, Geneva, from 23 to 31 January 2017. The proceedings are issued in two volumes. The present volume contains the resolutions and decisions, and relevant annexes. The summary records of the Board's discussions, and details regarding membership of committees, are issued in document EB140/2017/REC/2. The list of participants and officers is contained in document EB140/DIV./1 Rev.1.

CONTENTS

Page

Decisions

ANNEXES

Page

AGENDA[1]

1. Opening of the session

2. Adoption of the agenda

3. Report by the Director-General

4. Post of Director-General

    4.1 Nomination of candidates

    4.2 Draft contract

    4.3 Procedures for the conduct of the election

5. Report of the Programme, Budget and Administration Committee of the Executive Board

6. Report of the regional committees to the Executive Board

7. Preparedness, surveillance and response

    7.1 Health emergencies

    - WHO response in severe, large-scale emergencies
    - The Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme
    - Research and development for potentially epidemic diseases
    - Health workforce coordination in emergencies with health consequences

    7.2 Antimicrobial resistance

    7.3 Poliomyelitis

    7.4 Implementation of the International Health Regulations (2005)

    - Draft global implementation plan
    - Public health implications of the implementation of the Nagoya Protocol

[1] As adopted by the Board at its first meeting (23 January 2017).

11.3 Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): adolescents' health

12. Programme and budget matters

12.1 Overview of financial situation: Programme budget 2016–2017

12.2 Proposed programme budget 2018–2019

13. Financial matters

13.1 Scale of assessments for 2018–2019

13.2 [deleted]

14. Management and governance matters

14.1 Overview of WHO reform implementation

14.2 Governance reform: follow-up to decision WHA69(8) (2016)

14.3 Engagement with non-State actors

14.4 Reports of committees of the Executive Board

- Foundations and awards

14.5 [deleted]

14.6 Provisional agenda of the Seventieth World Health Assembly and date and place of the 141st session of the Executive Board

15. Staffing matters

15.1 Appointment of the Regional Director for the Eastern Mediterranean

15.2 Statement by the representative of the WHO staff associations

15.3 Human resources: update

- Criteria and principles for secondments from nongovernmental organizations, philanthropic foundations and academic institutions

15.4 Amendments to the Staff Regulations and Staff Rules

15.5 Report of the International Civil Service Commission

16. Matters for information

    16.1 Reports of advisory bodies

    - Expert committees and study groups

17. Closure of the session

LIST OF DOCUMENTS

EB140/1 Rev.1	Agenda[1]
EB140/1 (annotated)	Provisional agenda (annotated)
EB140/2	Report by the Director-General to the Executive Board at its 140th session
EB140/3	Post of Director-General Draft contract
EB140/4	Post of Director-General Options for the conduct of the election on the basis of paper-based voting[2]
EB140/5	Report of the Programme, Budget and Administration Committee of the Executive Board
EB140/6	Report of the regional committees to the Executive Board
EB140/7	Health emergencies WHO response in severe, large-scale emergencies
EB140/8	The Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme
EB140/9	Research and development for potentially epidemic diseases A blueprint for research and development preparedness and rapid research response
EB140/10	Health workforce coordination in emergencies with health consequences
EB140/11	Antimicrobial resistance
EB140/12	Improving the prevention, diagnosis and clinical management of sepsis
EB140/13	Poliomyelitis
EB140/14	Implementation of the International Health Regulations (2005) Draft global implementation plan

[1] See page ix.

[2] See Annex 3.

EB140/15	Implementation of the International Health Regulations (2005) Public health implications of the implementation of the Nagoya Protocol
EB140/16	Review of the Pandemic Influenza Preparedness Framework
EB140/16 Add.1	Financial and administrative implications for the Secretariat of decisions proposed for adoption by the Executive Board or Health Assembly[1]
EB140/17	Human resources for health and implementation of the outcomes of the United Nations' High-Level Commission on Health Employment and Economic Growth[2]
EB140/18	Principles for global consensus on the donation and management of blood, blood components and medical products of human origin
EB140/19	Addressing the global shortage of medicines and vaccines
EB140/20	Evaluation and review of the global strategy and plan of action on public health, innovation and intellectual property[3]
EB140/20 Add.1	Financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly[1]
EB140/21	Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination
EB140/22	Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination Terms of reference of the expert committee on health research and development
EB140/23 and EB140/23 Add.1	Member State mechanism on substandard/spurious/falsely-labelled/ falsified/counterfeit medical products[4]
EB140/24	Promoting the health of migrants
EB140/25	Global vaccine action plan
EB140/26	Global vector control response

[1] See Annex 8.

[2] See Annex 4.

[3] See Annex 6.

[4] See Annex 5.

EB140/27	Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018[1]
EB140/27 Add.1	Financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly[2]
EB140/28	Draft global action plan on the public health response to dementia
EB140/28 Add.1	Financial and administrative implications for the Secretariat of decisions proposed for adoption by the Executive Board or Health Assembly[2]
EB140/29	Public health dimension of the world drug problem
EB140/30	Report of the Commission on Ending Childhood Obesity: implementation plan
EB140/31	Cancer prevention and control in the context of an integrated approach
EB140/31 Add.1	Financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly[2]
EB140/32	Progress in the implementation of the 2030 Agenda for Sustainable Development
EB140/33	The role of the health sector in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond
EB140/34	Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): adolescents' health
EB140/35	Overview of financial situation: Programme budget 2016–2017
EB140/36	Proposed programme budget 2018–2019
EB140/37	Scale of assessments for 2018–2019
EB140/38	Overview of WHO reform implementation
EB140/39, EB140/40 and EB140/40 Add.1	Governance reform: follow-up to decision WHA69(8) (2016)

[1] See Annex 1.

[2] See Annex 8.

EB140/41	Engagement with non-State actors
EB140/42	Engagement with non-State actors Non-State actors in official relations with WHO[1]
EB140/43	Foundations and awards
EB140/44	Provisional agenda of the Seventieth World Health Assembly and date and place of the 141st session of the Executive Board
EB140/45	Appointment of the Regional Director for the Eastern Mediterranean
EB140/46	Human resources: update
EB140/47	Human resources: update Criteria and principles for secondments from nongovernmental organizations, philanthropic foundations and academic institutions
EB140/48	Amendments to the Staff Regulations and Staff Rules[2]
EB140/48 Add.1	Financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly[3]
EB140/49	Report of the International Civil Service Commission
EB140/50	Reports of advisory bodies Expert committees and study groups
EB140/50 Add.1	Reports of advisory bodies Expert committees and study groups Expert advisory panels and committees and their membership

Information documents

EB140/INF./1	Post of Director-General Nomination of candidates
EB140/INF./2	WHO presence in countries, territories and areas: 2015 report

[1] See Annex 7.

[2] See Annex 2.

[3] See Annex 8.

EB140/INF./3	Governance reform: follow-up to decision WHA69(8) (2016) Draft forward-looking planning schedule of expected agenda items for the Executive Board and Health Assembly
EB140/INF./4	Statement by the representative of the WHO staff associations
EB140/INF./5	Assessed contributions by Member States and Associate Members, showing a 10% increase in total assessed contribution financing for 2018–2019

Diverse documents

EB140/DIV./1 Rev.1	List of members and other participants
EB140/DIV./2	Preliminary daily timetable
EB140/DIV./3	List of decisions and resolutions
EB140/DIV./4	List of documents

RESOLUTIONS

EB140.R1 Appointment of the Regional Director for the Eastern Mediterranean

The Executive Board,

Considering the provisions of Article 52 of the Constitution of the World Health Organization;

Considering also the nomination made by the Regional Committee for the Eastern Mediterranean at its sixty-third session,[1]

1. APPOINTS Dr Mahmoud Fikri as Regional Director for the Eastern Mediterranean as from 1 February 2017;

2. AUTHORIZES the Director-General to issue to Dr Mahmoud Fikri a contract for a period of five years from 1 February 2017, subject to the provisions of the Staff Regulations and Staff Rules;

3. AUTHORIZES the Director-General to amend the conditions of employment of Dr Fikri as follows: "You will not participate in the United Nations Joint Staff Pension Fund but will instead receive as a monthly supplement the contribution that the Organization would have paid each month to the Pension Fund had you been a participant."

(Third meeting, 24 January 2017)

EB140.R2 Appreciation of the outgoing Regional Director for the Eastern Mediterranean

The Executive Board,

Desiring to express its appreciation to Dr Ala Din Alwan for his services to the World Health Organization;

Mindful of Dr Ala Din Alwan's lifelong, professional devotion to the cause of international health, and recalling especially his five years of service as Regional Director for the Eastern Mediterranean;

Recalling resolution EM/RC63/R.8 (2016), adopted by the Regional Committee for the Eastern Mediterranean, which designates Dr Ala Din Alwan as Regional Director Emeritus,

[1] Resolution EM/RC63/R.7 (2016).

1. EXPRESSES its profound gratitude and appreciation to Dr Ala Din Alwan for his invaluable and longstanding contribution to the work of WHO;

2. ADDRESSES to him on this occasion its sincere good wishes for many further years of service to humanity.

(Third meeting, 24 January 2017)

EB140.R3 Nomination for the post of Director-General

The Executive Board,

1. NOMINATES

Dr Tedros Adhanom Ghebreyesus

Dr David Nabarro

Dr Sania Nishtar

for the post of Director-General of the World Health Organization, in accordance with Article 31 of the Constitution of the World Health Organization;

2. SUBMITS this nomination to the Seventieth World Health Assembly.

(Seventh meeting, 25 January 2017)

EB140.R4 Post of Director-General: draft contract

The Executive Board,

In accordance with the requirements of Rule 107 of the Rules of Procedure of the World Health Assembly,

1. SUBMITS to the Seventieth World Health Assembly the draft contract establishing the terms and conditions of appointment of the Director-General;[1]

2. RECOMMENDS to the Seventieth World Health Assembly the adoption of the following resolution:

The Seventieth World Health Assembly,

I

Pursuant to Article 31 of the Constitution of the World Health Organization and Rule 107 of the Rules of Procedure of the World Health Assembly,

APPROVES the contract establishing the terms and conditions of appointment, salary and other emoluments for the post of Director-General;

[1] See Annex to this resolution.

II

Pursuant to Rule 110 of the Rules of Procedure of the World Health Assembly,

AUTHORIZES the President of the Seventieth World Health Assembly to sign this contract in the name of the Organization.

ANNEX

DRAFT CONTRACT OF THE DIRECTOR-GENERAL

THIS CONTRACT is made this …… day of May of the year two thousand and seventeen between the World Health Organization (hereinafter called the Organization) of the one part and …… (hereinafter called the Director-General) of the other part.

WHEREAS

(1) It is provided by Article 31 of the Constitution of the Organization that the Director-General of the Organization shall be appointed by the World Health Assembly (hereinafter called the Health Assembly) on the nomination of the Executive Board (hereinafter called the Board) on such terms as the Health Assembly may decide; and

(2) The Director-General has been duly appointed by the Health Assembly at its meeting held on the …… day of May of the year two thousand and seventeen for a period of five years.

NOW THIS CONTRACT WITNESSETH and it is hereby agreed as follows,

I. (1) The Director-General shall serve from the first day of July of the year two thousand and seventeen until the thirtieth day of June of the year two thousand and twenty-two, on which date the appointment and this Contract shall terminate.

(2) Subject to the authority of the Board, the Director-General shall exercise the functions of chief technical and administrative officer of the Organization and shall perform such duties as may be specified in the Constitution and in the rules of the Organization and/or as may be assigned to him or her by the Health Assembly or the Board.

(3) The Director-General fully commits to the responsible management and appropriate stewardship of WHO resources, including financial resources, human resources and physical resources, in an efficient and effective manner to achieve the Organization's objectives; an ethical culture, so that all Secretariat decisions and actions are informed by accountability, transparency, integrity, and respect; equitable geographical representation and gender balance in staff appointments and in accordance with Article 35 of WHO Constitution; follow-up of recommendations from the Organization's internal and external audits, and timeliness and transparency of official documentation.

(4) The Director-General shall be subject to the Staff Regulations of the Organization in so far as they may be applicable to him or her. In particular he or she shall not hold any other administrative post, and shall not receive emoluments from any outside sources in respect of activities relating to the Organization. He or she shall not engage in business or in any employment or activity that would interfere with his or her duties in the Organization.

(5) The Director-General, during the term of this appointment, shall enjoy all the privileges and immunities in keeping with the office by virtue of the Constitution of the Organization and any relevant arrangements already in force or to be concluded in the future.

(6) The Director-General may at any time give six months' notice of resignation in writing to the Board, which is authorized to accept such resignation on behalf of the Health Assembly; in which case, upon the expiration of the said period of notice, the Director-General shall cease to hold the appointment and this Contract shall terminate.

(7) The Health Assembly shall have the right, on the proposal of the Board and after hearing the Director-General and subject to at least six months' notice in writing, to terminate this Contract for reasons of exceptional gravity likely to prejudice the interests of the Organization.

II. (1) As from the first day of July of the year two thousand and seventeen the Director-General shall receive from the Organization an annual salary of two hundred and forty-one thousand, two hundred and seventy-six United States dollars, before staff assessment, resulting in a net salary (to be paid monthly) of one hundred and seventy-two thousand, and sixty-nine United States dollars per annum[1] or its equivalent in such other currency as may be mutually agreed between the parties to this Contract.

(2) In addition to the normal adjustments and allowances authorized to staff members under the Staff Rules, the Director-General shall receive an annual representation allowance of twenty-one thousand United States dollars or its equivalent in such other currency as may be mutually agreed between the parties to this Contract, to be paid monthly commencing on the first day of July of the year two thousand and seventeen. The representation allowance shall be used at his or her discretion entirely in respect of representation in connection with his or her official duties. He or she shall be entitled to such reimbursable allowances as travel allowances and removal costs on appointment, on subsequent change of official station, on termination of appointment, or on official travel and home leave travel.

III. The terms of the present Contract relating to rates of salary and representation allowance are subject to review and adjustment by the Health Assembly, on the proposal of the Board and after consultation with the Director-General, in order to bring them into conformity with any provision regarding the conditions of employment of staff members which the Health Assembly may decide to apply to staff members already in the service.

IV. If any question of interpretation or any dispute arises concerning this Contract that is not settled by negotiation or agreement, the matter shall be referred for final decision to the competent tribunal provided for in the Staff Rules.

WHEREUNTO we have set our hands the day and year first above written.

....

Director-General

President of the .....
World Health Assembly

(Seventh meeting, 25 January 2017)

[1] Indicative amounts only, pending approval by the Health Assembly on the Board's recommendations.

EB140.R5 Improving the prevention, diagnosis and management of sepsis

The Executive Board,

Having considered the report on improving the prevention, diagnosis and clinical management of sepsis,[1]

RECOMMENDS to the Seventieth World Health Assembly the adoption of the following resolution:[2]

The Seventieth World Health Assembly,

Concerned that sepsis continues to cause approximately six million deaths worldwide every year, most of which are preventable;

Recognizing that sepsis as a syndromic response to infection is the final common pathway to death from most infectious diseases worldwide;

Considering that sepsis follows a unique and time-critical clinical course, which in the early stages is highly amenable to treatment through early diagnosis and timely and appropriate clinical management;

Considering also that infections which may lead to sepsis can often be prevented through appropriate hand hygiene, access to vaccination programmes, improved sanitation and water quality and availability and other infection prevention and control best practices; and that forms of septicaemia associated with nosocomial infections are severe, hard to control and have high fatality rates;

Recognizing that while sepsis itself cannot always be predicted, its ill effects in terms of mortality and long term morbidity can be mitigated through early diagnosis and appropriate and timely clinical management;

Recognizing also the need to improve measures for the prevention of infections and control of the consequences of sepsis, due to inadequate infection prevention and control programmes, insufficient health education and recognition of early sepsis, inadequate access to affordable, timely, appropriate treatment and care, and insufficient laboratory services, as well as the lack of integrated approaches to the prevention and clinical management of sepsis;

Noting that health care-associated infections represent a common pathway through which sepsis can lead to an increased burden on health care resources;

Considering the need for an integrated approach to addressing sepsis that focuses on prevention, early recognition through clinical and laboratory services, and timely access to health care, including intensive care services, with reliability in the delivery of the basics of care, including intravenous fluids and the timely administration of antimicrobials where indicated;

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[1] Document EB140/12.

[2] See Annex 8 for the financial and administrative implications for the Secretariat of the resolution.

Acknowledging that:

(i) the inappropriate and excessive use of antimicrobials contributes to the threat of antimicrobial resistance;

(ii) the global action plan on antimicrobial resistance adopted in resolution WHA68.7 (2015),[1] as well as resolution WHA67.25 (2014), urged WHO to accelerate efforts to secure access to effective antimicrobials and to use them responsibly and prudently;

(iii) sepsis represents the most vital indication for the responsible use of effective antimicrobials for human health;

(iv) in the absence of appropriate and timely clinical management, including effective antimicrobials, sepsis would be almost universally fatal;

(v) ineffective or incomplete antimicrobial therapy for infections, including sepsis, may be a major contributor to the increasing threat of antimicrobial resistance;

(vi) the incidence of some resistant pathogens may be reduced by the use of appropriate vaccines; and

(vii) immunocompromised patients are most at risk from very serious forms of septicaemia;

Recognizing that many vaccine-preventable diseases are a major contributor to sepsis and reaffirming resolution WHA45.17 (1992) on immunization and vaccine quality, which urged Member States, inter alia, to integrate cost-effective and affordable new vaccines into national immunization programmes in countries where this is feasible;

Recognizing the importance of strong, functional health systems, which include organizational and therapeutic strategies in order to improve patient safety and outcomes from sepsis of bacterial origin;

Recognizing the need to prevent and control sepsis, to increase timely access to correct diagnosis and to provide appropriate treatment programmes;

Recognizing the advocacy efforts of stakeholders, in particular through existing activities held every year on 13 September[2] in many countries, to raise awareness regarding sepsis,

1. URGES Member States:[3]

(1) to include prevention, diagnosis and treatment of sepsis in national health system strengthening policies and processes, in the community and in health care settings according to international guidelines;

[1] See document WHA68/2015/REC/1, Annex 3.

[2] See document EB140/12 paragraph 10: civil society organizations promote a World Sepsis Day on 13 September.

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

(2) to reinforce existing or develop new strategies leading to strengthened infection prevention and control programmes, including by strengthening hygienic infrastructure, promoting hand hygiene, and other infection prevention and control best practices, clean childbirth practices, infection prevention practices in surgery, improvements in sanitation, nutrition and delivery of clean water, access to vaccination programmes, provision of effective personal protective equipment for health professionals and infection control in health care settings;

(3) to continue in their efforts to reduce antimicrobial resistance and promote the appropriate use of antimicrobials in accordance with the global action plan on antimicrobial resistance,[1] including development and implementation of comprehensive antimicrobial stewardship activities;

(4) to develop and implement standard and optimal care and strengthen medical countermeasures for diagnosing and managing sepsis in health emergencies, including outbreaks, through appropriate guidelines with a multisectoral approach;

(5) to increase public awareness of the risk of progression to sepsis from infectious diseases, through health education, including on patient safety, in order to ensure prompt initial contact between affected persons and the health care system;

(6) to develop training for all health professionals on infection prevention and patient safety, and on the importance of recognizing sepsis as a preventable and time-critical condition with urgent therapeutic need and of communicating with patients, relatives and other parties using the term "sepsis" in order to enhance public awareness;

(7) to promote research aimed at innovative means of diagnosing and treating sepsis across the lifespan, including research for new antimicrobial and alternative medicines, rapid diagnostic tests, vaccines and other important technologies, interventions and therapies;

(8) to apply and improve the use of the International Classification of Diseases system to establish the prevalence and profile of sepsis and antimicrobial resistance, and to develop and implement monitoring and evaluation tools in order to focus attention on and monitor progress towards improving outcomes from sepsis, including the development and fostering of specific epidemiologic surveillance systems and to guide evidence-based strategies for policy decisions related to preventive, diagnostic and treatment activities and access to relevant health care for survivors;

(9) to engage further in advocacy efforts to raise awareness of sepsis, in particular through supporting existing activities[2] held every year on 13 September in Member States;

2. REQUESTS the Director-General:

(1) to draw attention to the public health impact of sepsis, including by publishing a report on sepsis describing its global epidemiology and impact on the burden of disease and identifying successful approaches for integrating the timely diagnosis and management of sepsis into existing health systems, by the end of 2018;

[1] See document WHA68/2015/REC/1, Annex 3.

[2] See document EB140/12 paragraph 10: civil society organizations promote a World Sepsis Day on 13 September.

(2) to support Member States, as appropriate, to define standards and establish the necessary guidelines, infrastructures, laboratory capacity, strategies and tools for reducing the incidence of, mortality from and long-term complications of sepsis;

(3) to collaborate with other organizations in the United Nations system, partners, international organizations and other relevant stakeholders in enhancing access to quality, safe, efficacious and affordable types of treatments of sepsis, and infection prevention and control, including immunization, particularly in developing countries, while taking into account relevant existing initiatives;

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

(Seventh meeting, 25 January 2017)

EB140.R6 Scale of assessments for 2018–2019

The Executive Board,

Having considered the report on the scale of assessments for 2018–2019,[1]

RECOMMENDS to the Seventieth World Health Assembly the adoption of the following resolution:

The Seventieth World Health Assembly,

Having considered the report of the Director-General,

ADOPTS the scale of assessments of Members and Associate Members for the biennium 2018–2019 as set out below.

Members and Associate Members	WHO scale for 2018–2019 %
Afghanistan	0.0060
Albania	0.0080
Algeria	0.1610
Andorra	0.0060
Angola	0.0100
Antigua and Barbuda	0.0020
Argentina	0.8920
Armenia	0.0060
Australia	2.3371
Austria	0.7201
Azerbaijan	0.0600
Bahamas	0.0140
Bahrain	0.0440

[1] Document EB140/37.

Members and Associate Members	WHO scale for 2018–2019 %
Bangladesh	0.0100
Barbados	0.0070
Belarus	0.0560
Belgium	0.8851
Belize	0.0010
Benin	0.0030
Bhutan	0.0010
Bolivia (Plurinational State of)	0.0120
Bosnia and Herzegovina	0.0130
Botswana	0.0140
Brazil	3.8232
Brunei Darussalam	0.0290
Bulgaria	0.0450
Burkina Faso	0.0040
Burundi	0.0010
Cabo Verde	0.0010
Cambodia	0.0040
Cameroon	0.0100
Canada	2.9211
Central African Republic	0.0010
Chad	0.0050
Chile	0.3990
China	7.9212
Colombia	0.3220
Comoros	0.0010
Congo	0.0060
Cook Islands (not a Member of the United Nations)	0.0010
Costa Rica	0.0470
Côte d'Ivoire	0.0090
Croatia	0.0990
Cuba	0.0650
Cyprus	0.0430
Czechia	0.3440
Democratic People's Republic of Korea	0.0050
Democratic Republic of the Congo	0.0080
Denmark	0.5840
Djibouti	0.0010
Dominica	0.0010
Dominican Republic	0.0460
Ecuador	0.0670
Egypt	0.1520
El Salvador	0.0140
Equatorial Guinea	0.0100
Eritrea	0.0010

Members and Associate Members	WHO scale for 2018–2019 %
Estonia	0.0380
Ethiopia	0.0100
Fiji	0.0030
Finland	0.4560
France	4.8592
Gabon	0.0170
Gambia	0.0010
Georgia	0.0080
Germany	6.3892
Ghana	0.0160
Greece	0.4710
Grenada	0.0010
Guatemala	0.0280
Guinea	0.0020
Guinea-Bissau	0.0010
Guyana	0.0020
Haiti	0.0030
Honduras	0.0080
Hungary	0.1610
Iceland	0.0230
India	0.7370
Indonesia	0.5040
Iran (Islamic Republic of)	0.4710
Iraq	0.1290
Ireland	0.3350
Israel	0.4300
Italy	3.7482
Jamaica	0.0090
Japan	9.6802
Jordan	0.0200
Kazakhstan	0.1910
Kenya	0.0180
Kiribati	0.0010
Kuwait	0.2850
Kyrgyzstan	0.0020
Lao People’s Democratic Republic	0.0030
Latvia	0.0500
Lebanon	0.0460
Lesotho	0.0010
Liberia	0.0010
Libya	0.1250
Lithuania	0.0720
Luxembourg	0.0640
Madagascar	0.0030
Malawi	0.0020

Members and Associate Members	WHO scale for 2018–2019 %
Malaysia	0.3220
Maldives	0.0020
Mali	0.0030
Malta	0.0160
Marshall Islands	0.0010
Mauritania	0.0020
Mauritius	0.0120
Mexico	1.4351
Micronesia (Federated States of)	0.0010
Monaco	0.0100
Mongolia	0.0050
Montenegro	0.0040
Morocco	0.0540
Mozambique	0.0040
Myanmar	0.0100
Namibia	0.0100
Nauru	0.0010
Nepal	0.0060
Netherlands	1.4821
New Zealand	0.2680
Nicaragua	0.0040
Niger	0.0020
Nigeria	0.2090
Niue (not a Member of the United Nations)	0.0010
Norway	0.8491
Oman	0.1130
Pakistan	0.0930
Palau	0.0010
Panama	0.0340
Papua New Guinea	0.0040
Paraguay	0.0140
Peru	0.1360
Philippines	0.1650
Poland	0.8411
Portugal	0.3920
Puerto Rico (not a Member of the United Nations)	0.0010
Qatar	0.2690
Republic of Korea	2.0391
Republic of Moldova	0.0040
Romania	0.1840
Russian Federation	3.0882
Rwanda	0.0020
Saint Kitts and Nevis	0.0010
Saint Lucia	0.0010

Members and Associate Members	WHO scale for 2018–2019 %
Saint Vincent and the Grenadines	0.0010
Samoa	0.0010
San Marino	0.0030
Sao Tome and Principe	0.0010
Saudi Arabia	1.1461
Senegal	0.0050
Serbia	0.0320
Seychelles	0.0010
Sierra Leone	0.0010
Singapore	0.4470
Slovakia	0.1600
Slovenia	0.0840
Solomon Islands	0.0010
Somalia	0.0010
South Africa	0.3640
South Sudan	0.0030
Spain	2.4431
Sri Lanka	0.0310
Sudan	0.0100
Suriname	0.0060
Swaziland	0.0020
Sweden	0.9561
Switzerland	1.1401
Syrian Arab Republic	0.0240
Tajikistan	0.0040
Thailand	0.2910
The former Yugoslav Republic of Macedonia	0.0070
Timor-Leste	0.0030
Togo	0.0010
Tokelau (not a Member of the United Nations)	0.0010
Tonga	0.0010
Trinidad and Tobago	0.0340
Tunisia	0.0280
Turkey	1.0181
Turkmenistan	0.0260
Tuvalu	0.0010
Uganda	0.0090
Ukraine	0.1030
United Arab Emirates	0.6040
United Kingdom of Great Britain and Northern Ireland	4.4632
United Republic of Tanzania	0.0100
United States of America	22.0000
Uruguay	0.0790

Members and Associate Members	WHO scale for 2018–2019 %
Uzbekistan	0.0230
Vanuatu	0.0010
Venezuela (Bolivarian Republic of)	0.5710
Viet Nam	0.0580
Yemen	0.0100
Zambia	0.0070
Zimbabwe	0.0040
Total	**100.0000**

(Eighth meeting, 26 January 2017)

EB140.R7 Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018[1]

The Executive Board,

Having considered the report on preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018,[2]

RECOMMENDS to the Seventieth World Health Assembly the consideration of the following draft resolution:[3]

The Seventieth World Health Assembly,

Recalling resolutions WHA66.10 (2013) on the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, and WHA69.6 (2016) on responses to specific assignments in preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable diseases; United Nations General Assembly resolutions 66/2 (2011) on the Political Declaration of the High-level Meeting, 68/300 (2014) on the outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases, 69/313 (2015) on the Addis Ababa Action Agenda, and 70/1 (2015) on the 2030 Agenda for Sustainable Development; and United Nations Economic and Social Council resolutions 2013/12, 2014/10, 2015/8 and 2016/5 on the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases,

1. [ENDORSES] the updated Appendix 3 to the global action plan for the prevention and control of noncommunicable diseases 2013–2020;

[1] See Annex 1.

[2] Document EB140/27.

[3] See Annex 8 for the financial and administrative implications for the Secretariat of the resolution.

2. NOTES the workplan for the global coordination mechanism on the prevention and control of noncommunicable diseases covering the period 2018–2019;

3. URGES Member States:[1]

(1) to continue to implement resolutions WHA66.10 (2013) on the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and WHA69.6 (2016) on responses to specific assignments in preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable diseases; United Nations General Assembly resolutions 66/2 (2011) on the Political Declaration of the High-level Meeting, 68/300 (2014) on the outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases, 69/313 (2015) on the Addis Ababa Action Agenda, and 70/1 (2015) on the 2030 Agenda for Sustainable Development; and United Nations Economic and Social Council resolutions 2013/12, 2014/10, 2015/8 and 2016/5 on the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases, taking into account the updated Appendix 3 to the global action plan for the prevention and control of noncommunicable diseases 2013–2020;

(2) to support the preparation at the national, regional and international levels for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018;

4. REQUESTS the Director-General to submit a report on preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018, to the Seventy-first World Health Assembly in 2018, through the Executive Board.

(Thirteenth meeting, 28 January 2017)

EB140.R8 Confirmation of amendments to the Staff Rules: revised compensation package, related entitlements and salaries of staff[2]

The Executive Board,

Having considered the report on amendments to the Staff Regulations and Staff Rules,[3]

1. CONFIRMS, in accordance with Staff Regulation 12.2, the amendments to the Staff Rules that have been made by the Director-General with effect from 1 January 2017 concerning the remuneration of staff in the professional and higher categories;

2. ALSO CONFIRMS, in accordance with Staff Regulation 12.2, the amendments to the Staff Rules that have been made by the Director-General with effect from 1 January 2017 concerning definitions; the recruitment incentive; salaries; dependants' allowances; the mobility incentive, hardship allowance and non-family service allowance; the settling-in grant; the repatriation grant; the end-of-service grant; recruitment policies; assignment to duty; within-grade increase; home leave;

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

[2] See Annex 2.

[3] Document EB140/48.

travel of spouse and children; relocation shipment; the failure to exercise entitlement; expenses on death; abolition of post; and Appendix 1 to the Staff Rules;

3. FURTHER CONFIRMS, in accordance with Staff Regulation 12.2, the amendments to the Staff Rules that have been made by the Director-General, with effect from 1 January 2017 and applicable to the school year in progress on 1 January 2018, concerning the education grant; travel of staff members; travel of spouse and children; and Appendix 2 to the Staff Rules.

(Seventeenth meeting, 31 January 2017)

EB140.R9 Salaries of staff in ungraded positions and of the Director-General[1]

The Executive Board,

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

RECOMMENDS to the Seventieth World Health Assembly the adoption of the following resolution:

The Seventieth World Health Assembly,

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

1. ESTABLISHES the salaries of Assistant Directors-General and Regional Directors at US$ 174 373 gross per annum, with a corresponding net salary of US$ 130 586;

2. ALSO ESTABLISHES the salary of the Deputy Director-General at US$ 192 236 gross per annum, with a corresponding net salary of US$ 142 376;

3. FURTHER ESTABLISHES the salary of the Director-General at US$ 241 276 gross per annum, with a corresponding net salary of US$ 172 069;

4. DECIDES that those adjustments in remuneration shall take effect on 1 January 2017.

(Seventeenth meeting, 31 January 2017)

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[1] See Annex 2.

[2] Document EB140/48.

DECISIONS

EB140(1) Post of Director-General: options for the conduct of the election at the Executive Board on the basis of paper-based voting[1]

The Executive Board, having considered the report on the post of Director-General: options for the conduct of the election on the basis of paper-based voting,[2] decided to use a paper-based voting system for the nomination of the Director-General.

(Second meeting, 23 January 2017)

EB140(2) Post of Director-General: procedures for the conduct of the election at the Health Assembly on the basis of paper-based voting[1]

The Executive Board, having considered the report on the post of Director-General: options for the conduct of the election on the basis of paper-based voting,[2] decided:

(1) to recommend that the Seventieth World Health Assembly decide to use a paper-based voting system for the appointment of the Director-General;

(2) to recommend that the Seventieth World Health Assembly implement the proposals outlined in the table in document EB140/4 and adopt the proposed amendments in the Annex to document EB140/4 in accordance with Rule 119 of the Rules of Procedure of the World Health Assembly.[3]

(Second meeting, 23 January 2017)

EB140(3) Human resources for health and implementation of the outcomes of the United Nations' High-Level Commission on Health Employment and Economic Growth[4,5]

The Executive Board, having considered the report on human resources for health and implementation of the outcomes of the United Nations' High-Level Commission on Health Employment and Economic Growth,[6] and having welcomed the report of the High-Level Commission on Health Employment and Economic Growth that was presented in September 2016 at the United Nations General Assembly and the High-Level Ministerial Meeting on Health Employment and Economic Growth that was convened in December 2016, decided to request the Director-General:

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[1] See Annex 3.

[2] Document EB140/4.

[3] See Annex 3.

[4] See Annex 4.

[5] See Annex 8 for the financial and administrative implications for the Secretariat of the decision.

[6] Document EB140/17.

(1) to finalize in time for the Seventieth World Health Assembly, in collaboration with ILO, OECD and relevant regional and specialized entities, in consultation with Member States[1] and in keeping with the objectives of the Global Strategy on Human Resources for Health: Workforce 2030,[2] a draft five-year action plan 2017–2021 supporting the implementation of the recommendations of the High-Level Commission on Health Employment and Economic Growth;

(2) to submit the draft five-year action plan 2017–2021 for consideration by the Seventieth World Health Assembly;

(3) to work with Member States[1] to adopt measures focusing on the key recommendations of the report of the High-Level Commission on Health Employment and Economic Growth, including the development of intersectoral plans and investment in transformative education, promoting decent job creation in the health and social sectors and mutual benefit from the international mobility of health workers.

(Ninth meeting, 26 January 2017)

EB140(4) Poliomyelitis[3]

The Executive Board, having considered the reports on poliomyelitis[4] and human resources: update,[5]

(1) recalled resolution WHA68.3 (2015) on poliomyelitis and encouraged Member States to ensure its full implementation;

(2) recalled previous discussions on the human resources aspects of the Global Polio Eradication Initiative at the Executive Board and the Health Assembly, in particular on the issue of potential indemnities resulting from the termination of staff contracts;

(3) underlined the need for continued emphasis on an effective endgame effort to eradicate polio and the importance of ensuring that the Global Polio Eradication Initiative is fit for purpose, with adequate levels of qualified staff;

(4) emphasized the urgent need for effective transition planning, in line with the three main aims outlined in paragraph 19 of document EB140/13;

(5) further emphasized the need to continue to provide the appropriate, situation-specific and focused interventions, in particular in relation to human resources and budgetary requirements, to the regions and countries where transmission has not been interrupted;

(6) recognized the major and systemic challenges facing WHO that will result from the current winding-down of the Global Polio Eradication Initiative;

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

[2] See resolution WHA69.19 (2016) and document WHA69/2016/REC/1, Annex 7.

[3] See Annex 8 for the financial and administrative implications for the Secretariat of the decision.

[4] Document EB140/13.

[5] Document EB140/46.

(7) called for appropriate prioritization of opportunities for internal reassignment so as to reduce potential liabilities and indemnities, in particular to strengthen the WHO Health Emergencies Programme and the Expanded Programme on Immunization, with emphasis given to retaining the highest-performing staff;

(8) emphasized the need to accelerate opportunities to shift or reprofile the 43% of staff funded by the Global Polio Eradication Initiative who work in polio-free countries, while ensuring that appropriate resources remain in place for surveillance;

(9) reiterated its expectation that recruitment of staff for the Global Polio Eradication Initiative should be carried out without incurring any avoidable costs resulting from the foreseeable future termination of contracts, including by synchronizing contract end dates, and requested WHO to ensure that standard contracts that meet this requirement are available and are used;

(10) decided to request the Director-General:

(a) to present to the Seventieth World Health Assembly a report that outlines the programmatic, financial, and human resource-related risks resulting from the current winding-down and eventual discontinuation of the Global Polio Eradication Initiative, as well as an update on actions taken and planned to mitigate those risks while ensuring that essential polio-related functions are maintained, and to present a first draft of that report to a meeting of Member States before the end of April 2017;

(b) to continue reporting regularly to the Health Assembly, through the Executive Board, on the planning and implementation of the transition process.

(Tenth meeting, 27 January 2017)

EB140(5) Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits[1]

The Executive Board, having considered the report of the 2016 Pandemic Influenza Preparedness (PIP) Framework Review Group;[2] recalling section 6.14.5 of the PIP Framework, according to which the Director-General will propose to the Executive Board which proportion of partnership contributions should be used for inter-pandemic preparedness measures, and which proportion should be reserved for response activities in the event of a pandemic, based on the advice of the PIP Advisory Group; recalling also decision EB131(2) (2012), wherein it was decided that, over the next five years (2012−2016) approximately 70% of contributions should be used for pandemic preparedness measures and approximately 30% should be reserved for response activities, recognizing the need for and usefulness of flexibility in allocating funds; further recalling that in April 2016 the PIP Advisory Group recommended to the Director-General that all decisions relating to the implementation of partnership contributions be extended to 31 December 2017, including Executive Board decision EB131(2), and that the recommendation of the Advisory Group was therefore to extend also the proportional division between pandemic preparedness measures and response activities agreed through decision EB131(2);[3] noting that the Director-General accepted this recommendation; noting also that the report of the 2016 PIP Framework Review Group will be submitted to the

[1] See Annex 8 for the financial and administrative implications for the Secretariat of the decision.

[2] Document EB140/16, Annex 1.

[3] http://www.who.int/influenza/pip/ag_april2016_MeetingRpt.pdf?ua=1, paragraph 45 (accessed 30 November 2016).

Seventieth World Health Assembly in May 2017 and that discussion on the report at the Health Assembly may be relevant to the development of the next proposal for the proportional division of funds between pandemic preparedness measures and response activities; having further considered documents EB140/15 and EB140/16 and the recommendations, in particular recommendation 36, of the 2016 PIP Framework Review Group contained in document EB140/16, decided the following:

(1) to extend until 28 February 2018 the application of decision EB131(2) (2012);

(2) to request the Director-General to propose, in accordance with section 6.14.5 of the Pandemic Influenza Preparedness (PIP) Framework, a new proposal on which proportion of partnership contributions should be used for inter-pandemic preparedness measures, and which proportion should be reserved for response activities in the event of a pandemic, based on the advice of the PIP Advisory Group, for consideration by the Executive Board at its 142nd session in January 2018;

(3) to request the Director-General to continue consultations with the secretariat of the Convention on Biological Diversity and other relevant international organizations, as appropriate, in the context of existing international commitments on access to pathogens and fair and equitable sharing of benefits, in the interest of public health, and to report thereon to the Seventieth World Health Assembly.

(Tenth meeting, 27 January 2017)

EB140(6) Member State mechanism on substandard/spurious/falsely-labelled/ falsified/counterfeit medical products[1]

The Executive Board, having considered the report of the fifth meeting of the Member State mechanism on substandard/spurious/falsely-labelled/falsified/counterfeit medical products[2] and resolution WHA65.19 (2012),[3] decided:

(1) to endorse the definitions as set out in Appendix 3 to the Annex to document EB140/23;

(2) to recommend that the Seventieth World Health Assembly:

(a) endorse the definitions as set out in Appendix 3 to the Annex to document EB140/23;

(b) request the Director-General to replace the term “substandard/spurious/ falsely-labelled/falsified/counterfeit medical products” with “substandard and falsified medical products” as the term to be used in the name of the Member State mechanism and in all future documentation on the subject of medical products of this type.

(Eleventh meeting, 27 January 2017)

[1] See Annex 5.

[2] Document EB140/23.

[3] See document WHA65/2012/REC/1, and in particular the footnote in the first paragraph of the Annex to the resolution.

EB140(7) Draft global action plan on the public health response to dementia[1]

The Executive Board, having considered the draft global action plan on the public health response to dementia 2017–2025,[2] decided to recommend to the Seventieth World Health Assembly the adoption of the following decision:

> The Seventieth World Health Assembly, having considered the draft global action plan on the public health response to dementia 2017–2025,
>
> (1) endorsed the global action plan on the public health response to dementia 2017–2025;
>
> (2) urged Member States[3] to develop, as soon as practicable, ambitious national responses to the overall implementation of the global action plan on the public health response to dementia 2017–2025;
>
> (3) requested the Director-General to submit a report on progress made in implementing this decision to the Health Assembly in 2020, 2023 and 2026.

(Fourteenth meeting, 30 January 2017)

EB140(8) Overall programme review of the global strategy and plan of action on public health, innovation and intellectual property[1,4]

The Executive Board, having considered the report on the evaluation and review of the global strategy and plan of action on public health, innovation and intellectual property,[5] decided to approve the terms of reference of the overall programme review of the global strategy and plan of action on public health, innovation and intellectual property, set out in Annex 6 of document EB140/2017/REC/1; and to request the Secretariat to develop an indication of funding requirements and possible sources of funding to meet the implementation costs of the recommendations of the programme review, and to present these to the Seventy-first World Health Assembly in 2018, through the Executive Board at its 142nd session.

(Seventeenth meeting, 31 January 2017)

EB140(9) Promoting the health of refugees and migrants[1]

The Executive Board, taking note of the report on promoting the health of migrants,[6] recalling resolution WHA61.17 (2008) on the health of migrants, and reaffirming the New York Declaration for Refugees and Migrants, in particular its annexes on the global compact on refugees and on the global compact for safe, orderly and regular migration, decided to request the Director-General:

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[1] See Annex 8 for the financial and administrative implications for the Secretariat of the decision.

[2] Document EB140/28, Annex.

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

[4] See Annex 6.

[5] Document EB140/20.

[6] Document EB140/24.

(1) to prepare, in full consultation and cooperation with Member States,[1] and in cooperation with the International Organization for Migration and UNHCR and other relevant stakeholders, a draft framework of priorities and guiding principles to promote the health of refugees and migrants, to be presented to the Seventieth World Health Assembly;

(2) to make every possible effort, in close collaboration with Member States, and based on the guiding principles, to ensure that health aspects are adequately addressed in the development of the global compact on refugees and the global compact for safe, orderly and regular migration, in close collaboration with relevant international organizations, and to report thereon to the Seventy-first World Health Assembly;

(3) to conduct a situation analysis by identifying and collecting experiences and lessons learned on the health of refugees and migrants in each region, in order to provide inputs for the development of the framework of priorities and guiding principles to promote the health of refugees and migrants, and to report thereon to the Seventy-first World Health Assembly;

(4) to develop, in full consultation and cooperation with Member States,[1] and in cooperation with other relevant stakeholders, such as the International Organization for Migration and UNHCR, a draft global action plan on the health of refugees and migrants, to be considered for adoption by the Seventy-second World Health Assembly, through the Executive Board at its 144th session.

(Seventeenth meeting, 31 January 2017)

EB140(10) Engagement with non-State actors[2]

The Executive Board, having considered the report on non-State actors in official relations with WHO, including the review of one third of the non-State actors in official relations with WHO,[3]

(1) decided:

(a) to admit into official relations with WHO the following non-State actors: Bill & Melinda Gates Foundation; Grand Challenges Canada; International Rescue Committee; Knowledge Ecology International; and The Fred Hollows Foundation;

(b) to discontinue official relations with the following non-State actors: Inclusion International; Inter-African Committee on Traditional Practices affecting the Health of Women and Children; International Centre for Trade and Sustainable Development; World Association for Psychosocial Rehabilitation; and World Association for Sexual Health;

(2) noted with appreciation their collaboration with WHO and commended their continuing dedication to the work of WHO, and decided to maintain in official relations with WHO the 58 non-State actors whose names are listed in Annex 2 to document EB140/42;

(3) further noted the reports on European Generic medicines Association, Handicap International Federation, International Alliance of Women, International Federation of Business

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

[2] See Annex 7.

[3] Document EB140/42.

and Professional Women, International Insulin Foundation, International Spinal Cord Society, International Union for Health Promotion and Education, Italian Association of Friends of Raoul Follereau, Medical Women's International Association, Rehabilitation International, and World Federation of the Deaf; and that plans for collaboration have yet to be agreed; and decided to defer the review of relations with these non-State actors until the 142nd session of the Executive Board in January 2018, at which time reports should be presented to the Board on the agreed plans for collaboration and on the status of relations.

(Seventeenth meeting, 31 January 2017)

EB140(11) Award of the Dr A.T. Shousha Foundation Prize

The Executive Board, having considered the report of the Dr A.T. Shousha Foundation Prize Committee, awarded the Dr A.T. Shousha Foundation Prize for 2017 to Dr Yasmin Ahmed Jaffer of Oman for her significant contribution to public health in Oman. The laureate will receive the equivalent of 2500 Swiss francs in United States dollars.

(Eighteenth meeting, 31 January 2017)

EB140(12) Award of the Sasakawa Health Prize

The Executive Board, having considered the report of the Sasakawa Health Prize Selection Panel, awarded the Sasakawa Health Prize for 2017 to Dr Arslan Rinchin of Mongolia for his remarkable contribution to the advancement of primary health care in Mongolia. The laureate will receive US$ 30 000.

(Eighteenth meeting, 31 January 2017)

EB140(13) Award of the United Arab Emirates Health Foundation Prize

The Executive Board, having considered the report of the United Arab Emirates Health Foundation Selection Panel, awarded the United Arab Emirates Health Foundation Prize for 2017 to Professor Lô Boubou Baïdy of Mauritania, who is being honoured for his substantial contribution to the establishment of the national blood transfusion centre and development of blood transfusion services, as well as for his fight against viral hepatitis, HIV/AIDS and sexually transmitted infections in Mauritania. The laureate will receive US$ 20 000.

(Eighteenth meeting, 31 January 2017)

EB140(14) Award of the Dr LEE Jong-wook Memorial Prize for Public Health

The Executive Board, having considered the report of the Dr LEE Jong-wook Memorial Prize Selection Panel, awarded the Dr LEE Jong-wook Memorial Prize for Public Health for 2017 to the Henry Reeve International Medical Brigade of Cuba for its outstanding contribution to public health. The laureate will receive US$ 100 000.

(Eighteenth meeting, 31 January 2017)

EB140(15) Provisional agenda of the Seventieth World Health Assembly

The Executive Board, having considered the report of the Director-General on the provisional agenda for the Seventieth World Health Assembly,[1] and recalling its earlier decision that the Seventieth World Health Assembly should be held at the Palais des Nations in Geneva, opening on Monday, 22 May 2017, and closing no later than Wednesday, 31 May 2017,[2] approved the provisional agenda of the Seventieth World Health Assembly, as amended.

(Eighteenth meeting, 31 January 2017)

EB140(16) Date and place of the 141st session of the Executive Board

The Executive Board decided that its 141st session should be convened on 1 and 2 June 2017, at WHO headquarters, Geneva.

(Eighteenth meeting, 31 January 2017)

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[1] Document EB140/44.

[2] See decision EB139(11) (2016).

ANNEXES

ANNEX 1

Draft updated Appendix 3 to the global action plan for the prevention and control of noncommunicable diseases 2013–2020 and proposed workplan for the global coordination mechanism on the prevention and control of noncommunicable diseases covering the period 2018–2019[1]

[EB140/27, Annexes 1 and 3 – 5 December 2016]

[Appendix 1]

DRAFT UPDATED APPENDIX 3 TO THE GLOBAL ACTION PLAN FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES 2013–2020

What is Appendix 3?

1. Appendix 3 is a part of the global action plan for the prevention and control of noncommunicable diseases 2013–2020. It consists of a menu of policy options and cost-effective interventions to assist Member States in implementing, as appropriate for national context (without prejudice to the sovereign rights of nations to determine taxation among other policies), actions to achieve the nine voluntary global targets for the prevention and control of noncommunicable diseases. They are presented under the six objectives of the global action plan. The list of interventions is not exhaustive but is intended to provide information and guidance on the effectiveness and cost-effectiveness of population-based and individual interventions based on current evidence, and to serve as the basis for future work to develop and expand the evidence base. Countries are implementing the global action plan, as appropriate for the national context, and Appendix 3 has been used in the development and prioritization of national action plans.

Why update Appendix 3?

2. Appendix 3 has been updated at the request of Member States, to take into consideration the emergence of new evidence of cost-effectiveness and the issuance of new WHO recommendations since the adoption of the global action plan in 2013, and also to refine the existing formulation of some interventions based on lessons learned from the use of the first version. The global action plan ends in 2020, and any future updates will be considered as part of the development of any subsequent global strategies for noncommunicable diseases.

What has changed?

3. The menu of options listed for objectives 1 (raising the priority accorded to noncommunicable diseases), 2 (strengthening leadership and governance), 5 (research) and 6 (monitoring and evaluation)

[1] See resolution EB140.R7.

are process-related recommendations and have not changed. Within objectives 3 (risk factors) and 4 (health systems), in the updated Appendix 3, there are now a total of 86 interventions and overarching/enabling actions, representing an expansion from the original list of 62. This increase is due to the greater availability of scientific evidence and to the need to disaggregate some previous interventions (such as "reduce salt intake") into more clearly defined and implementable actions.

4. As in the original Appendix 3, a select number of interventions, considered to be the most cost-effective and feasible for implementation, are identified in bold text. In the updated Appendix 3, 16 interventions are listed in bold,[1] as compared to 14 in the original version, and the method for identifying such interventions has been modified.[2] Other interventions, for which cost-effectiveness analysis by the WHO's Choosing interventions that are cost-effective (WHO-CHOICE) project could be completed, are listed in descending order of cost-effectiveness.[3] Interventions that are mentioned in WHO's guidelines and technical documents where WHO-CHOICE analysis has not been able to be conducted are also listed. Care needs to be taken when interpreting these lists; for example, the absence of WHO-CHOICE analysis does not necessarily mean that an intervention is not cost-effective, affordable or feasible – rather, there were methodological or capacity reasons for which the WHO-CHOICE analysis could not be completed. The economic analyses in the technical annex,[4] upon which this list is based, give an assessment of cost-effectiveness ratio, health impact and the economic cost of implementation. These economic results present a set of parameters for consideration by Member States, but it must be emphasized that such global analyses should be accompanied by analyses in the local context. Other WHO tools, such as the OneHealth Tool,[5] are available to help individual countries cost specific interventions in their national context.

The importance of non-financial considerations

5. Cost-effectiveness analysis is a useful tool but it has limitations and should not be used as the sole basis for decision-making. When selecting interventions for the prevention and control of noncommunicable diseases, consideration should be given to effectiveness, cost-effectiveness, affordability, implementation capacity, feasibility, according to national circumstances, and impact on health equity of interventions, and to the need to implement a combination of population-wide policy interventions and individual interventions.

6. Critical non-financial considerations that may affect the feasibility of certain interventions in some settings are set out in a new column in the updated Appendix 3. Many of the interventions for the prevention and control of noncommunicable diseases involve multisectoral benefits and costs that need to be taken into account, and examples of the multisectoral aspects of these interventions are outlined in Appendix 5 to the global action plan. It was not possible to provide an equity rating for

[1] With an average cost-effectiveness ratio of ≤I$ 100/disability-adjusted life-year averted in low and lower-middle income countries. The international dollar (I$) is a hypothetical unit of currency that has the same purchasing power parity that the United States dollar had in the United States at a given point in time.

[2] The listing of interventions in bold text in this updated Appendix 3 is based on economic analyses only. Critical non-financial considerations that may affect the feasibility of certain interventions in some settings are set out in a new column in the updated Appendix 3.

[3] Based on cost-effectiveness ratio in low- and middle-income settings.

[4] The draft technical annex is available in the WHO discussion paper dated 25 July 2016 on the draft updated Appendix 3, which is available at: http://who.int/ncds/governance/appendix3-update/en/ (accessed 10 October 2016). It will be updated after the 140th session of the Executive Board, before the Seventieth World Health Assembly.

[5] http://www.who.int/choice/onehealthtool/en/ (accessed 10 October 2016).

each intervention, given the importance of context, but, in general, population-based interventions, including fiscal policies and environmental changes, show the most potential to reduce inequalities in the prevention and control of noncommunicable diseases.[1] Individual interventions, especially those involving education and awareness campaigns, are most likely to widen inequalities and should be accompanied by measures to assess and address other barriers to behaviour change. For any intervention, the impact on health inequalities needs to be considered and evaluated, in order to ensure that policies are effective across all population groups.[2]

Technical annex

7. Based on feedback from experts and Member States, this updated Appendix 3 is accompanied by a technical annex.[3] The annex provides more detailed information about the methodology used to identify and analyse interventions, and presents the results of the economic analysis separately for low and lower-middle income, and upper-middle and high income countries. The Secretariat will explore options to provide an interactive web-tool, to enable users to compare and rank the information according to their own needs. The detailed description of the WHO-CHOICE methods for these analyses, including the assumptions, strength of evidence and the individual studies used to inform the development of models for each intervention, will be published separately as peer-reviewed scientific papers, which will be publicly available through open access.

	Menu of policy options	Critical non-financial considerations[a]	WHO tools[b]
OBJECTIVE 1			
Overarching/enabling actions	• Raise public and political awareness, understanding and practice about prevention and control of NCDs • Integrate NCDs into the social and development agenda and poverty alleviation strategies • Strengthen international cooperation for resource mobilization, capacity-building, health workforce training and exchange of information on lessons learned and best practices • Engage and mobilize civil society and the private sector as appropriate and strengthen international cooperation to support implementation of the action plan at global, regional and national levels • Implement other policy options in objective 1		– WHO global status report on NCDs 2014 – WHO fact sheets – Noncommunicable diseases country profiles (2014) – IARC GLOBOCAN 2008

[1] See for example: http://www.euro.who.int/__data/assets/pdf_file/0003/247638/obesity-090514.pdf; http://www.euro.who.int/__data/assets/pdf_file/0005/247640/tobacco-090514.pdf?ua=1; and http://www.euro.who.int/__data/assets/pdf_file/0003/247629/Alcohol-and-Inequities.pdf (accessed 10 October 2016).

[2] For example, accompanying tobacco price increases with smoking cessation support for the poor, and ensuring food product reformulation involves the entire product range and not just the more expensive options.

[3] The draft technical annex is available in the WHO discussion paper dated 25 July 2016 on the draft updated Appendix 3, which is available at http://who.int/ncds/governance/appendix3-update/en/ (accessed 10 October 2016). It will be updated after the 140th session of the Executive Board, before the Seventieth World Health Assembly.

Menu of policy options		Critical non-financial considerations[a]	WHO tools[b]
OBJECTIVE 2			
Overarching/enabling actions	• Prioritize and increase, as needed, budgetary allocations for prevention and control of NCDs, without prejudice to the sovereign right of nations to determine taxation and other policies • Assess national capacity for prevention and control of NCDs • Develop and implement a national multisectoral policy and plan for the prevention and control of NCDs through multistakeholder engagement • Implement other policy options in objective 2 to strengthen national capacity including human and institutional capacity, leadership, governance, multisectoral action and partnerships for prevention and control of noncommunicable diseases		– United Nations Secretary-General's Note A/67/373 – NCD country capacity survey tool – Online NCD MAP Tool for developing, implementing and monitoring national multisectoral action plans
OBJECTIVE 3			
TOBACCO USE			
Overarching/enabling actions	*For the Parties to the WHO Framework Convention on Tobacco Control (WHO FCTC):* • Strengthen the effective implementation of the WHO FCTC and its protocols • Establish and operationalize national mechanisms for coordination of the WHO FCTC implementation as part of national strategy with specific mandate, responsibilities and resources *For the Member States that are not Parties to the WHO FCTC:* • Consider implementing the measures set out in the WHO FCTC and its protocols, as the foundational instrument in global tobacco control		– The WHO FCTC, its guidelines and its Protocol to Eliminate Illicit Trade in Tobacco Products – MPOWER capacity-building modules to reduce demand for tobacco, in line with the WHO FCTC (2011–2014) – MPOWER policy measures (2009) – WHO reports on the global tobacco epidemic (2008, 2009, 2011, 2012, 2015)
	• **Increase excise taxes and prices on tobacco products**		– Assessing the national capacity to implement effective tobacco control policies (2011) – Technical resource for country implementation of the WHO Framework Convention on Tobacco Control Article 5.3 (2012)

	Menu of policy options	Critical non-financial considerations[a]	WHO tools[b]
WHO-CHOICE analysis available[c]			– WHO tobacco tax simulation model (TaXSiM) (2014) – WHO technical manual on tobacco tax administration (2010) – IARC Handbook of Cancer Prevention/ Volume 12 (2008), Volume 13 (2009), Volume 14 (2011)
	• **Implement plain/standardized packaging and/or large graphic health warnings on all tobacco packages** • **Enact and enforce comprehensive bans on tobacco advertising, promotion and sponsorship, including cross-border advertising and using modern means of communication** • **Eliminate exposure to second-hand tobacco smoke in all indoor workplaces, public places, public transport, and in all outdoor mass-gathering places**		– Plain packaging of tobacco products: evidence, design and implementation (2016) – Banning tobacco advertising, promotion and sponsorship – What you need to know (2013) – Making your city smoke-free: brochure (2011) and workshop package (2013) – Smoke-free movies: from evidence to action – third edition (2016) – Protect people from tobacco smoke: smoke-free environments (2011) – A guide to tobacco-free mega events (2009)
	• **Implement effective mass media campaigns that educate the public about the harms of smoking/tobacco use and second hand smoke** • Provide cost-covered, effective and population-wide support (including brief advice, national toll-free quit line services and mCessation) for tobacco cessation to all those who want to quit		– Policy recommendations on protection from exposure to second-hand tobacco smoke (2007) – Strengthening health systems for treating tobacco dependence in primary care (2013)

Menu of policy options		Critical non-financial considerations[a]	WHO tools[b]
			– Training for tobacco quit line counsellors: telephone counselling (2014) – Developing and improving national toll-free tobacco quit line services (2011)
WHO-CHOICE analysis not available	• Implement measures to minimize illicit trade in tobacco products		– Confronting the tobacco epidemic in a new era of trade and investment liberalization (2012)
HARMFUL USE OF ALCOHOL			
Overarching/enabling actions	• Implement the WHO global strategy to reduce harmful use of alcohol through multisectoral actions in the recommended target areas • Strengthen leadership and increase commitment and capacity to address the harmful use of alcohol • Increase awareness and strengthen the knowledge base on the magnitude and nature of problems caused by harmful use of alcohol by awareness programmes, operational research, improved monitoring and surveillance systems		– Global strategy to reduce the harmful use of alcohol (2010) (WHA63.13) – WHO global status report on alcohol and health (2014) – WHO fact sheets and policy briefs on harmful use of alcohol
WHO-CHOICE analysis available[c]	• **Increase excise taxes on alcoholic beverages** • **Enact and enforce bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media)** • **Enact and enforce restrictions on the physical availability of retailed alcohol (via reduced density of retail outlets and reduced hours of sale)**	– Requires an effective system for tax administration and should be combined with efforts to prevent tax avoidance and tax evasion – Requires capacity for implementing and enforcing regulations and legislation – Formal controls on sale need to be complemented by actions addressing illicit or informally	– WHO implementation toolkit for the global strategy to reduce the harmful use of alcohol (2017) – Resource book on alcohol taxation (2017)

Menu of policy options		Critical non-financial considerations[a]	WHO tools[b]
WHO-CHOICE analysis available[c]		produced alcohol	
	• Enact and enforce drink-driving laws and blood alcohol concentration limits via sobriety checkpoints	– Requires allocation of sufficient human resources and equipment	
	• Provide brief psychosocial intervention for persons with hazardous and harmful alcohol use	– Requires trained providers at all levels of health care	– Manuals for the alcohol, smoking and substance involvement screening test (ASSIST) and the ASSIST-linked brief interventions (2011) – Brief intervention for hazardous and harmful drinking: a manual for use in primary care (2001)
WHO-CHOICE analysis not available	• Carry out regular reviews of prices in relation to level of inflation and income • Establish minimum prices for alcohol where applicable • Enact and enforce an appropriate minimum age for purchase or consumption of alcoholic beverages • Restrict or ban promotions of alcoholic beverages in connection with sponsorships and activities targeting young people • Provide prevention, treatment and care for alcohol use disorders and comorbid conditions in health and social services • Provide consumer information about, and label, alcoholic beverages to indicate, the harm related to alcohol		– mhGAP intervention guide 2.0 (2016)
UNHEALTHY DIET			
Overarching/enabling actions	• Implement the global strategy on diet, physical activity and health		– Global strategy on diet, physical activity and health (2004)
	• Implement the WHO recommendations on the marketing of foods and non-alcoholic beverages to children		– WHO Set of recommendations on the marketing of foods and non-alcoholic beverages to children (2010)

Menu of policy options		Critical non-financial considerations[a]	WHO tools[b]
			– Framework for implementing the set of recommendations on the marketing of foods and non-alcoholic beverages to children (2012)
WHO-CHOICE analysis available[c]	• **Reduce salt intake through the reformulation of food products to contain less salt and the setting of target levels for the amount of salt in foods and meals** • **Reduce salt intake through the establishment of a supportive environment in public institutions such as hospitals, schools, workplaces and nursing homes, to enable lower sodium options to be provided** • **Reduce salt intake through a behaviour change communication and mass media campaign** • **Reduce salt intake through the implementation of front-of-pack labelling** • Eliminate industrial *trans*-fats through the development of legislation to ban their use in the food chain • Reduce sugar consumption through effective taxation on sugar-sweetened beverages[1]	– Requires multisectoral actions with relevant ministries and support by civil society – Regulatory capacity along with multisectoral action is needed	– WHO nutrient profile model(s) for regulating marketing food and non-alcoholic beverages to children – Report of the Commission on Ending Childhood Obesity (2016) – WHO e-Library of Evidence for Nutrition Actions (eLENA) – Fact sheet on healthy diet – Interventions on diet and physical activity: what works: summary report (2009) – Guideline: sodium intake for adults and children (2012) – Guideline: potassium intake for adults and children (2012) – SHAKE the salt habit: technical package for salt reduction (2016) – Guideline: sugars intake for adults and children (2015) – Fiscal policies for diet and the prevention of noncommunicable diseases (2016)

[1] WHO-CHOICE analysis for this intervention is currently in progress and will be completed before the Seventieth World Health Assembly.

	Menu of policy options	Critical non-financial considerations[a]	WHO tools[b]
WHO-CHOICE analysis not available	• Promote and support exclusive breastfeeding for the first 6 months of life, including promotion of breastfeeding • Implement subsidies to increase the intake of fruits and vegetables • Replace *trans*-fats and saturated fats with unsaturated fats through reformulation, labelling, fiscal policies or agricultural policies • Limiting portion and package size to reduce energy intake and the risk of overweight/obesity • Implement nutrition education and counselling in different settings (for example, in preschools, schools, workplaces and hospitals) to increase the intake of fruits and vegetables • Implement nutrition labelling to reduce total energy intake (kcal), sugars, sodium and fats		– Global strategy for infant and young child feeding (2003) – International Code of Marketing of Breast-milk Substitutes (1981) – Evidence for the ten steps to successful breastfeeding (1998) – Marketing of breast-milk substitutes: national implementation of the international code: status report (2016) – Baby-friendly hospital initiative: revised, updated and expanded for integrated care (2009) – Five keys to a healthy diet (2016) – Fruit and vegetables for health (2004) – Population-based approaches to childhood obesity prevention (2012) – Essential nutrition actions: improving maternal, newborn, infant and young child health and nutrition (2013) – Planning guide for national implementation of the Global Strategy for Infant and Young Child Feeding (2007) – School policy framework: implementation of the WHO global strategy on diet, physical activity and health (2008)

Menu of policy options		Critical non-financial considerations[a]	WHO tools[b]
	• Implement mass media campaign on healthy diets, including social marketing to reduce the intake of total fat, saturated fats, sugars and salt, and promote the intake of fruits and vegetables		– Development of a framework on the nutrition-friendly schools initiative (2006) – Prioritizing areas for action in the field of population-based prevention of childhood obesity (2012)
PHYSICAL INACTIVITY			
Overarching/enabling actions	• Implement the global strategy on diet, physical activity and health		– Global recommendations on physical activity for health (2010) – Report of the Commission on Ending Childhood Obesity (2016) – Interventions on diet and physical activity: what works: summary report (2009) – WHO global strategy on diet, physical activity and health: a framework to monitor and evaluate implementation (2008) – Physical activity technical package (2016)
WHO-CHOICE analysis available[c]	• Provide physical activity counselling and referral as part of routine primary health care services through the use of a brief intervention • Implement public awareness and motivational communications for physical activity, including mass media campaign for physical activity behaviour change[1]	– Requires sufficient, trained capacity in primary care	

[1] WHO-CHOICE analysis for this intervention is currently in progress and will be completed before the Seventieth World Health Assembly.

	Menu of policy options	Critical non-financial considerations[a]	WHO tools[b]
WHO-CHOICE analysis not available	• Ensure that macro-level urban design incorporates the core elements of residential density, connected street networks that include sidewalks, easy access to a diversity of destinations and access to public transport • Implement whole-of-school programme that includes quality physical education, availability of adequate facilities and programs to support physical activity for all children • Provide convenient and safe access to quality public open space and adequate infrastructure to support walking and cycling • Implement multi-component workplace physical activity programmes • Promotion of physical activity through organized sport groups and clubs, programmes and events	– Requires involvement and capacity of other sectors apart from health	– Guide for population-based approaches to increasing levels of physical activity (2007) – Prioritizing areas for action in the field of population-based prevention of childhood obesity (2012) – Population-based approaches to childhood obesity prevention (2012) – School policy framework (2008) – Promoting physical activity in schools: an important element of a health-promoting school (2007) – Quality physical education policy package (2014) – Preventing noncommunicable diseases in the workplace through diet and physical activity (2008)
OBJECTIVE 4			
	• Integrate very cost-effective noncommunicable disease interventions into the basic primary health care package with referral systems to all levels of care to advance the universal health coverage agenda		– Implementation tools: WHO package of essential noncommunicable (PEN) disease interventions for primary health care in low-resource settings (2013)

Menu of policy options		Critical non-financial considerations[a]	WHO tools[b]
Overarching/enabling actions	• Explore viable health financing mechanisms and innovative economic tools supported by evidence • Scale up early detection and coverage, prioritizing very cost-effective high-impact interventions including cost-effective interventions to address behavioural risk factors • Train the health workforce and strengthen the capacity of health systems, particularly at the primary care level, to address the prevention and control of noncommunicable diseases • Improve the availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases, in both public and private facilities • Implement other cost-effective interventions and policy options in objective 4 to strengthen and orient health systems to address noncommunicable diseases and risk factors through people-centred health care and universal health coverage • Develop and implement a palliative care policy, including access to opioids analgesics for pain relief, together with training for health workers • Expand the use of digital technologies to increase health service access and efficacy for NCD prevention, and to reduce the costs in health care delivery		– WHO model list of essential medicines – Scaling-up the capacity of nursing and midwifery services to contribute to the Millennium Development Goals – Scaling up action against noncommunicable diseases: How much will it cost? (2011) – Health systems financing: the path to universal coverage (2010)
CARDIOVASCULAR DISEASE AND DIABETES			
	• **Drug therapy (including glycaemic control for diabetes mellitus and control of hypertension using a total risk[1] approach) and counselling to individuals who have had a heart attack or stroke and to persons with high risk (≥ 30%) of a fatal and non-fatal cardiovascular event in the next 10 years**	– Feasible in all resource settings, including by non-physician health workers	– Global atlas on cardiovascular disease prevention and control (2011)

[1] Total risk is defined as the probability of an individual experiencing a cardiovascular disease event (for example, myocardial infarction or stroke) over a given period of time, for example 10 years.

	Menu of policy options	Critical non-financial considerations[a]	WHO tools[b]
WHO-CHOICE analysis available[c]	• **Drug therapy (including glycaemic control for diabetes mellitus and control of hypertension using a total risk approach) and counselling to individuals who have had a heart attack or stroke and to persons with moderate to high risk (≥ 20%) of a fatal and non-fatal cardiovascular event in the next 10 years**	– Applying lower risk threshold increases health gain but also increases implementation cost	– WHO ISH cardiovascular risk prediction charts – Guidelines for primary health care in low-resource settings (2012)
	• Treatment of new cases of acute myocardial infarction[1] with either: acetylsalicylic acid, or acetylsalicylic acid and clopidogrel, or thrombolysis, or primary percutaneous coronary interventions (PCI)	– Selection of option depends on health system capacity	
	• Treatment of acute ischemic stroke with intravenous thrombolytic therapy	– Needs capacity to diagnose ischaemic stroke	– A global brief on hypertension (2013)
	• Primary prevention of rheumatic fever and rheumatic heart diseases by increasing appropriate treatment of streptococcal pharyngitis at the primary care level • Secondary prevention of rheumatic fever and rheumatic heart disease by developing a register of patients who receive regular prophylactic penicillin	– Depending on prevalence in specific countries or sub-populations	– Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: what's new (2015) – HEARTS technical package for cardiovascular disease management in primary health care (2016)
WHO-CHOICE analysis not available	• Treatment of congestive cardiac failure with angiotensin-converting-enzyme inhibitor, beta-blocker and diuretic • Cardiac rehabilitation post myocardial infarction • Anticoagulation for medium-and high-risk non-valvular atrial fibrillation and for mitral stenosis with atrial fibrillation • Low-dose acetylsalicylic acid for ischemic stroke • Care of acute stroke and rehabilitation in stroke units		

[1] Costing assumes hospital care in all scenarios.

Menu of policy options		Critical non-financial considerations[a]	WHO tools[b]
DIABETES			
WHO-CHOICE analysis available[c]	• Preventive foot care for people with diabetes (including educational programmes, access to appropriate footwear, multidisciplinary clinics) • Diabetic retinopathy screening for all diabetes patients and laser photocoagulation for prevention of blindness • Effective glycaemic control for people with diabetes, along with standard home glucose monitoring for people treated with insulin to reduce diabetes complications	– Requires systems for patient recall	– Guidelines for primary health care in low-resource settings (2012) – Global report on diabetes (2016)
WHO-CHOICE analysis not available	• Lifestyle interventions for preventing type 2 diabetes • Influenza vaccination for patients with diabetes • Preconception care among women of reproductive age who have diabetes including patient education and intensive glucose management • Screening of people with diabetes for proteinuria and treatment with angiotensin-converting-enzyme inhibitor for the prevention and delay of renal disease		
CANCER			

WHO-CHOICE analysis available[c]	• **Vaccination against human papillomavirus (2 doses) of 9–13 year old girls**
	• **Prevention of cervical cancer by screening women aged 30–49, either through:**
	  • **Visual inspection with acetic acid linked with timely treatment of pre-cancerous lesions**
	  • **Pap smear (cervical cytology) every 3–5 years linked with timely treatment of pre-cancerous lesions**
	  • **Human papillomavirus test every 5 years linked with timely treatment of pre-cancerous lesions**
		– Visual inspection with acetic acid is feasible in low resource settings, including with non-physician health workers
		– Pap smear requires cytopathology capacity
		– Requires systems for organized, population-based screening and quality control
			– National cancer control programmes core capacity self-assessment tool (2011)
			– Guidelines for primary health care in low-resource settings (2012)
			– Cancer control: knowledge into action, six modules (2008)

	Menu of policy options	Critical non-financial considerations[a]	WHO tools[b]
WHO-CHOICE analysis available[c]	• Treatment of cervical cancer stages I and II with either surgery or radiotherapy +/- chemotherapy • Treatment of breast cancer stages I and II with surgery +/- systemic therapy		– Comprehensive cervical cancer control: A guide to essential practice – Second edition (2014) – WHO position paper on mammography screening (2014) – Cryosurgical equipment for the treatment of precancerous cervical lesions and prevention of cervical cancer (2012) – Monitoring national cervical cancer prevention and control programmes (2013) – Use of cryotherapy for cervical intraepithelial neoplasia (2011)
	• Screening with mammography (once every 2 years for women aged 50-69 years) linked with timely diagnosis and treatment of breast cancer	– Requires systems for organized, population-based screening and quality control	– Global atlas of palliative care at the end of life (2014)
	• Treatment of colorectal cancer stages I and II with surgery +/- chemotherapy and radiotherapy		– Planning and implementing palliative care services: a guide for programme managers (2016)
	• Basic palliative care for cancer: home-based and hospital care with multi-disciplinary team and access to opiates and essential supportive medicines	– Requires access to controlled medicines for pain relief	– Guidelines on the pharmacological treatment of persisting pain in children with medical illnesses (2012)
WHO-CHOICE analysis not available	• Prevention of liver cancer through hepatitis B immunization • Oral cancer screening in high-risk groups (for example, tobacco users, betel-nut chewers) linked with timely treatment • Population-based colorectal cancer screening, including through a faecal occult blood test, as appropriate, at age >50, linked with timely treatment		– Practices to improve coverage of the hepatitis B birth dose vaccine (2013)

Menu of policy options		Critical non-financial considerations[a]	WHO tools[b]
CHRONIC RESPIRATORY DISEASE			
WHO-CHOICE analysis available[c]	• Symptom relief for patients with asthma with inhaled salbutamol • Symptom relief for patients with chronic obstructive pulmonary disease with inhaled salbutamol • Treatment of asthma using low dose inhaled beclometasone and short acting beta agonist		– Guidelines for primary health care in low-resource settings (2012) – Selected pollutants: WHO guideline for indoor air quality (2010) – WHO air quality guidelines for particular matter, ozone, nitrogen, dioxide and sulphur dioxide (2005)
WHO-CHOICE analysis not available	• Access to improved stoves and cleaner fuels to reduce indoor air pollution • Cost-effective interventions to prevent occupational lung diseases, for example, from exposure to silica, asbestos • Influenza vaccination for patients with chronic obstructive pulmonary disease		– WHO guidelines for indoor air quality: Household fuel combustion (2014) – Outline for the development of national programmes for elimination of asbestos-related diseases (2014)
OBJECTIVE 5			
Overarching/enabling actions	• Develop and implement a prioritized national research agenda for noncommunicable diseases • Prioritize budgetary allocation for research on noncommunicable disease prevention and control • Strengthen human resources and institutional capacity for research • Strengthen research capacity through cooperation with foreign and domestic research institutes • Implement other policy options in objective 5 to promote and support national capacity for high-quality research, development and innovation		– Prioritized research agenda for the prevention and control of noncommunicable diseases 2011 – Research for universal health coverage: World Health Report 2013 – Global strategy and plan of action on public health, innovation and intellectual property (WHA61.21)

	Menu of policy options	Critical non-financial considerations[a]	WHO tools[b]
OBJECTIVE 6			
Overarching/enabling actions	• Develop national targets and indicators based on global monitoring framework and linked with a multisectoral policy and plans • Strengthen human resources and institutional capacity for surveillance and monitoring and evaluation • Establish and/or strengthen a comprehensive noncommunicable disease surveillance system, including reliable registration of deaths by cause, cancer registration, periodic data collection on risk factors and monitoring national response • Integrate noncommunicable disease surveillance and monitoring into national health information systems • Implement other policy options in objective 6 to monitor trends and determinants of noncommunicable diseases and evaluate progress in their prevention and control		– Noncommunicable diseases progress monitor 2015 – Global monitoring framework – Verbal autopsy instrument – STEPwise approach to surveillance – Global Tobacco Surveillance System – Global Information System on Alcohol and Health – Global database on the Implementation of Nutrition Action (GINA) – Global school-based student health survey, ICD-10 training tool – Service Availability and Readiness (SARA) assessment tool – IARC GLOBOCAN 2008

[a] Cost-effectiveness alone does not imply the feasibility of an intervention in all settings. This column highlights some of the critical non-financial aspects that should be taken into account when considering the suitability of interventions for specific contexts.

[b] An up-to-date list of WHO tools and resources for each objective can be found at: http://www.who.int/nmh/ncd-tools/en/ (accessed 10 October 2016).

[c] Interventions in bold font are those with an average cost-effectiveness ratio of ≤I$100/DALY averted in low and lower-middle income countries.

[Appendix 2]

PROPOSED WORKPLAN FOR THE GLOBAL COORDINATION MECHANISM ON THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES COVERING THE PERIOD 2018–2019

1. This workplan sets out the activities of the global coordination mechanism on the prevention and control of noncommunicable diseases, including those of time-bound Working Groups, covering the period 2018–2019. The workplan takes into account the terms of reference for the global

coordination mechanism,[1] the workplans covering the periods 2014–2015[2] and 2016–2017,[3] the global action plan for the prevention and control of noncommunicable diseases 2013–2020,[4] the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases,[5] the Outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases,[6] and the 2030 Agenda for Sustainable Development.

2. This workplan takes into consideration the 2030 Agenda for Sustainable Development and the need to enhance multisectoral and multistakeholder advocacy, engagement and action that supports whole-of-government approaches across sectors beyond health and whole-of-society approaches engaging all sectors of society, in order to achieve the noncommunicable disease-related targets of the Sustainable Development Goals.

3. During the implementation of this workplan, account will be taken of: the evaluations mentioned in paragraphs 16 and 17 of document EB140/27; the Outcome document to be adopted at the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018; and outcomes adopted at other relevant high-level meetings, forums and events convened by the United Nations General Assembly as part of the systematic follow-up and review of the implementation of the 2030 Agenda for Sustainable Development at the global level.[7]

4. As with the previous two workplans, this workplan is organized around five objectives, in line with the five functions of the global coordination mechanism stated in its terms of reference. It will be implemented between January 2018 and December 2019 in line with the time frame of the Proposed programme budget 2018–2019 and the budgetary provisions related to the activities of the global coordination mechanism included in that programme budget. This workplan will be fully integrated into programme area 2.1 (noncommunicable diseases) of the Proposed programme budget 2018–2019, which will be operationalized through Programme Area Network 2.1, in accordance with established operating procedures.

5. As with the workplan covering the period 2016–2017, and in line with the scope and purpose of the global coordination mechanism, the draft third workplan covering the period 2018–2019 aims to facilitate and enhance the coordination of activities, multistakeholder engagement and action across sectors at the local, national, regional and global levels, in order to contribute to the implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020, while avoiding duplication of efforts, using resources in an efficient and results-oriented way, and

[1] Document A67/14 Add.1, Annex, Appendix 1.

[2] Document A67/14 Add.3 Rev.1.

[3] Document A68/11, Annex 3.

[4] Endorsed by the Sixty-sixth World Health Assembly in resolution WHA66.10 (2013).

[5] Adopted by the United Nations General Assembly in resolution 66/2 (2011).

[6] Adopted by the United Nations General Assembly in resolution 68/300 (2014).

[7] Adopted by the United Nations General Assembly in resolution 70/299 (2016).

safeguarding WHO and public health from any undue influence by any form of real, perceived or potential conflicts of interest.[1]

OBJECTIVES AND ACTIONS

Objective 1. Advocate for and raise awareness of the urgency of implementing the global action plan for the prevention and control of noncommunicable diseases 2013–2020, and mainstream the prevention and control of noncommunicable diseases in the international development agenda.

Action 1.1: Continue the implementation and development of the global communications campaign launched in 2016, with a focus on achieving the noncommunicable disease-related targets of the Sustainable Development Goals and realizing the commitments to prevent and control noncommunicable diseases, as agreed by Member States.[2]

Action 1.2: Raise awareness of the need to accelerate action to strengthen national responses to noncommunicable diseases by facilitating and enhancing the coordination of activities, multistakeholder engagement and actions across sectors by participants in the global coordination mechanism at high-level political forums.

Action 1.3: Conduct at least one dialogue to facilitate and enhance the coordination of activities, multistakeholder engagement and action across sectors at the local, national, regional and global levels, to support Member States in realizing their commitments to address noncommunicable diseases.

Objective 2. Disseminate knowledge and share information based on scientific evidence and/or best practices regarding implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020.

Action 2.1: Continue to facilitate the exchange of information on noncommunicable disease-related research and its translation, identify barriers to research generation and translation, and facilitate innovation in order to enhance the knowledge base for ongoing national, regional and global action.

Action 2.2: Curate a resource library through the portal[3] of the global coordination mechanism by the end of 2018, which will include relevant and appropriate materials that promote multisectoral and multistakeholder action on noncommunicable diseases.

Action 2.3: Support knowledge dissemination and information sharing, including through communities of practice and webinars to support the implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020 at the national, regional and global levels.

Action 2.4: Develop and disseminate an annual activity report describing progress made in the implementation of the workplan.

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[1] Document A67/14 Add.1, Annex, Appendix 1, paragraph 1.

[2] See United Nations General Assembly resolutions 66/2 (2011) and 68/300 (2014).

[3] See http://www.gcmportal.org/ (accessed 3 November 2016).

Objective 3. Provide a forum to identify barriers and share innovative solutions and actions for the implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020 and to promote sustained actions across sectors.

Action 3.1: Establish at least one working group to recommend ways and means of encouraging Member States and non-State actors to realize the commitments made to prevent and control noncommunicable diseases through multisectoral and multistakeholder approaches.

Action 3.2: Conduct at least one meeting of participants in the global coordination mechanism to facilitate and enhance the coordination of activities, multistakeholder engagement and action across sectors at the local, national, regional and global levels.

Objective 4. Advance multisectoral action by identifying and promoting sustained actions across sectors that can contribute to and support the implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020.

Action 4.1: Establish strategic roundtables aimed at supporting governments in strengthening their whole-of-government approaches across sectors beyond health and whole-of-society approaches engaging all sectors of society, in collaboration with relevant WHO technical units, the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases, and other stakeholders, as appropriate.

Action 4.2: Work with relevant WHO technical units and the United Nations Inter-Agency Task Force in efforts to meet the requests by Member States to implement the recommendations of the WHO working groups of the global coordination mechanism.

Action 4.3: Continue to contribute to an integrated initiative, in collaboration with relevant WHO technical units and offices, the United Nations Inter-Agency Task Force and other stakeholders, that ensures an appropriate, coordinated and comprehensive response to provide support to Member States that are committed to making fast-track progress towards achieving the nine voluntary global targets for noncommunicable diseases by 2025, and the noncommunicable disease-related targets of the Sustainable Development Goals by 2030.

Objective 5. Identify and share information on existing and potential sources of finance and cooperation mechanisms at the local, national, regional and global levels for implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020.

Action 5.1: Continue to promote the implementation of the approach that WHO will have developed to register and publish contributions of non-State actors to the achievement of the nine voluntary targets for noncommunicable diseases.

Action 5.2: Map and publish the commitments made by participants in the global coordination mechanism to implement the global action plan for the prevention and control of noncommunicable diseases 2013–2020.[1]

[1] See document A67/14 Add.1, Annex, Appendix 1, paragraph 22.

Action 5.3: Establish an ongoing dialogue to explore the feasibility of establishing voluntary innovative financing mechanisms and partnerships[1] to develop and implement national noncommunicable disease responses through multisectoral and multistakeholder approaches.

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[1] In accordance with Sustainable Development Goal 17 (Strengthen the means of implementation and revitalize the global partnership for sustainable development).

ANNEX 2

Confirmation of amendments to the Staff Rules[1]

[EB140/48 – 21 November 2016]

1. Amendments to the Staff Rules made by the Director-General are submitted for confirmation by the Executive Board in accordance with Staff Regulation 12.2.[2]

2. In accordance with Staff Regulation 12.1, proposed amendments to the Staff Regulations are submitted to the Executive Board, which is requested to recommend their adoption by the Seventieth World Health Assembly.

3. The amendments described in this document stem from the decisions taken by the United Nations General Assembly at its seventieth session, in resolution 70/244 adopted on 23 December 2015,[3] on the basis of recommendations made by the International Civil Service Commission in its report for the year 2015,[4] and decisions expected to be taken at its seventy-first session, on the basis of recommendations made by the Commission in its report for the year 2016.[5] Should the United Nations General Assembly not approve the Commission's recommendations, an addendum to the present report will be issued.

4. The financial implications of the amendments for the biennium 2016–2017 involve additional costs under the Programme budget 2016–2017. They are set out in the report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly, together with the financial implications beyond the biennium 2016–2017,[6] and in the paragraphs below.

5. The proposed amendments to the Staff Rules are set out in the [appendices] to the present document.

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[1] See resolutions EB140.R8 and EB140.R9.

[2] The Staff Regulations and Staff Rules are available at http://www.who.int/employment/staff_regulations_rules/EN_staff_regulations_and_staff_rules.pdf?ua=1 (accessed 1 November 2016).

[3] See http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/70/244 (accessed 1 November 2016).

[4] See http://icsc.un.org/resources/pdfs/ar/AR2015.pdf (accessed 1 November 2016).

[5] See http://icsc.un.org/resources/pdfs/ar/AR2016.pdf (accessed 1 November 2016)

[6] See Annex 8.

AMENDMENTS CONSIDERED NECESSARY IN THE LIGHT OF DECISIONS TAKEN BY THE UNITED NATIONS GENERAL ASSEMBLY AT ITS SEVENTIETH SESSION AND DECISIONS EXPECTED TO BE TAKEN AT ITS SEVENTY-FIRST SESSION ON THE BASIS OF RECOMMENDATIONS BY THE INTERNATIONAL CIVIL SERVICE COMMISSION

Salaries of staff

Remuneration of staff in the professional and higher categories

6. In 2015, at its seventieth session, the United Nations General Assembly approved the introduction of a new unified base/floor salary scale structure, eliminating the distinction between single and dependency net base salary rates with effect from 1 January 2017. Compensation for recognized dependants will be provided through respective allowances.

7. In its report for 2016, the Commission recommended to the United Nations General Assembly that the new unified base/floor salary scale for the professional and higher categories should be increased by 1.02% through the standard consolidation method of increasing the base salary and commensurately decreasing post adjustment multiplier points, resulting in no change in net take-home pay, with effect from 1 January 2017.

8. Amendments to Appendix 1 to the Staff Rules have been prepared accordingly and are set out in [Appendix 2] to the present document.

Remuneration of staff in ungraded posts and of the Director-General

9. Subject to the decision of the United Nations General Assembly in respect of the recommendation in paragraph 7 above, the Director-General proposes, in accordance with Staff Regulation 3.1, that the Executive Board recommend to the Seventieth World Health Assembly modifications in the salaries of Assistant Directors-General and Regional Directors. Thus, as from 1 January 2017, the gross salary for Assistant Directors-General and Regional Directors would be US$ 174 373 per annum, and the net salary US$ 130 586.

10. Based on the adjustments to salaries described above, the salary modification to be authorized by the Health Assembly for the Deputy Director-General would entail, as from 1 January 2017, a gross salary of US$ 192 236 per annum, with a corresponding net salary of US$ 142 376.

11. The salary adjustments described above would also imply modifications to the salary of the Director-General. The salary to be authorized by the Health Assembly, as from 1 January 2017, would therefore be US$ 241 276 per annum gross, US$ 172 069 net.

Revised compensation package and related entitlements

12. The amendments to the Staff Rules set out in this part are mandated by United Nations General Assembly resolution 70/244.

Definition of “single parent”

13. Staff Rule 310 is amended to provide a definition of “single parent” to be used to determine eligibility for the single parent allowance (resolution 70/244, Part III, para. 19).

Recruitment incentive

14. Staff Rule 315 is introduced to provide for an incentive payment for the recruitment of experts in highly specialized fields in instances where the Organization is unable to attract suitably qualified personnel (resolution 70/244, Part III, para. 53).

Salaries

15. Staff Rule 330 is amended to reflect new staff assessment rates (resolution 70/244, Part III, para. 12).

Dependants' allowances

16. Staff Rule 340 is amended to reflect the introduction of the dependant spouse allowance and single parent allowance in place of the dependency rate of salary in the previous salary scale (resolution 70/244, Part III, paras 17, 18 and 19).

Education grant

17. Staff Rule 350 is amended to:

(a) make the education grant for post-secondary education payable up to the end of the school year in which the child reaches the age of 25, completes four years of post-secondary studies or attains a first post-secondary degree, whichever is earlier;

(b) limit admissible expenses to tuition (including mother tongue tuition) and enrolment-related fees only;

(c) limit the eligibility for a lump sum for boarding to staff members assigned outside category H duty stations and for primary and secondary levels only; and

(d) provide for the reimbursement outside the education grant scheme of capital assessment fees charged by educational institutions. (resolution 70/244, Part III, paras 26–29, and 31).

18. The revised education grant scheme and related Staff Rule amendments shall be introduced as of the school year in progress on 1 January 2018. (resolution 70/244, Part III, para. 25).

Mobility incentive, hardship allowance and non-family service allowance

19. Staff Rule 360 is amended to:

(a) discontinue the non-removal allowance;

(b) replace the additional hardship allowance by the non-family service allowance; and

(c) replace the mobility allowance by the mobility incentive, which would apply to staff with five consecutive years of service and from their second assignment, and which would exclude category H duty stations (resolution 70/244, Part III, paras 46–48).

Settling-in grant

20. Staff Rule 365 is amended to replace the assignment grant by a settling-in grant and eliminate the second lump-sum payment previously payable under certain conditions (resolution 70/244, Part III, para. 45).

Repatriation grant

21. Staff Rule 370 is amended to increase the eligibility requirement for the repatriation grant from one to five years of continuous service (resolution 70/244, Part III, para. 39).

Assignment to duty

22. Staff Rule 510 is amended to remove the definition of “removal” and “non-removal” duty stations (resolution 70/244, Part III, para. 41).

Within-grade increase

23. Staff Rule 550 is amended to reflect the new periodicity between within-grade increases and to remove the accelerated step increase for demonstrated language proficiency (resolution 70/244, Part III, paras 20 and 22).

Home leave

24. Staff Rule 640 is amended to reflect the discontinuation of accelerated home leave travel except at certain duty stations as defined by the Commission (resolution 70/244, Part III, para. 51).

Travel of staff members

25. Staff Rule 810 is amended to reflect the entitlement to education grant travel for a staff member who receives assistance with boarding expenses for a child attending primary or secondary school (in other words, the entitlement is not applicable to a child in post-secondary education) (resolution 70/244, Part III, para. 30).

Travel of spouse and children

26. Staff Rule 820 is amended to:

(a) eliminate the entitlement to a second education grant round trip (resolution 70/244, Part III, para. 30);

(b) restrict eligibility for the annual round trip to the educational institution to children of staff in receipt of assistance with boarding expenses under the education grant scheme (resolution 70/244, Part III, para. 30);

(c) remove the requirement that a child of a staff member installed at a duty station must remain in the duty station for at least six months, recognizing that a child of staff in receipt of assistance with boarding expenses will not meet this requirement (this amendment is proposed to correct an anomaly discovered during the review of WHO’s education grant scheme).

Relocation shipment

27. Staff Rule 855 is amended to discontinue the distinction between R (with removal entitlement) and NR (non-removal) assignments, and to introduce the concept of and terminology concerning relocation shipment (resolution 70/244, Part III, para. 44).

Failure to exercise entitlement

28. Staff Rule 860 is amended to reflect the new terminology concerning relocation shipment (resolution 70/244, Part III, para. 44).

Expenses on death

29. Staff Rule 870 is amended to reflect the new terminology concerning relocation shipment (resolution 70/244, Part III, para. 44).

Appendix 1 to the Staff Rules [Appendix 2]

30. Appendix 1 to the Staff Rules, as set out in [Appendix 2] to the present document, is amended to reflect the new unified base/floor salary scale as adopted by the United Nations General Assembly at its seventieth session (resolution 70/244, para. 6), with revisions as recommended by the Commission in its report for the year 2016.[1]

Appendix 2 to the Staff Rules [Appendix 3]

31. Appendix 2 to the Staff Rules, as set out in [Appendix 3] to the present document, is amended to reflect the global sliding scale for the reimbursement of admissible expenses under the education grant scheme, consisting of seven brackets, with declining reimbursement levels ranging from 86% at the lowest bracket to 61% at the sixth bracket and no reimbursement at the seventh bracket, as published by the Commission and approved by the General Assembly (resolution 70/244, Part III, para. 28).

Financial implications

32. In its report for 2015, the Commission estimated the total annual cost savings for all organizations across the United Nations common system to be US$ 113.2 million (a 2%–3% reduction in staff costs). However, resolution 70/244 provides for increases in entitlements not presented in the Commission's 2015 report, notably a single parent allowance of 6% of net remuneration. Consequently, the Commission's projections will need to be adjusted in due course. Furthermore, the figures provided in the Commission's report are subject to changes in staff numbers.

33. It should be noted that immediate savings will not be realized because of implementation costs in the form of enhancements to enterprise resource planning systems (amounting to approximately US$ 2 million for WHO) and transitional costs associated with staff entitlements. Accordingly, the cost savings arising from the changes to the periodicity of within-grade step increases and the reduction in education grant costs related to fewer admissible expenses and limited boarding and travel allowances, will be realized only in the long term. Although WHO expects to see benefits in terms of

[1] To be submitted for approval by the United Nations General Assembly at its Seventy-first session.

greater efficiency and simplicity in the administration of entitlements, the transitional measures (applicable for up to five years in some cases) put in place to avoid adversely affecting staff at the time of the changes will bring administrative complexity in the payroll system for several years.

Amendments in relation to the extension of the mandatory age of separation to 65 for staff members appointed on or before 1 January 2014

34. Staff Rule 1020.1 is amended to implement the new mandatory age of separation of 65 for staff members who became participants in the United Nations Joint Staff Pension Fund before 1 January 2014 (resolution 70/244, Part I).

35. Staff Rule 410 is amended to reflect 65 years as the normal age limit for recruitment, rather than 62, in line with the new mandatory age of separation (resolution 70/244, Part I).

36. Further to the recommendation made by the Commission in its report for the year 2012[1] and United Nations General Assembly resolution 67/257 (2013), the WHO's Staff Rules were amended to raise the mandatory age of separation to 65 for staff recruited after 1 January 2014.[2] Since then, the pending issue has been whether the increase of the mandatory age of separation to 65 would apply also to staff recruited before 1 January 2014. This was addressed in resolution 70/244, in which the United Nations General Assembly decided that the mandatory age of separation for staff recruited before 1 January 2014 should be raised by the organizations of the United Nations common system to 65 years, at the latest by 1 January 2018, "taking into account the acquired rights of staff".

Increase of the mandatory age of separation "taking into account the acquired rights of staff"

37. The acquired rights that need to be taken into account when increasing the mandatory age of separation to 65 are the right of staff members hired before 1 January 1990 (with a retirement age of 60) or after 1 January 1990 (with a retirement age of 62), and before 1 January 2014, to retire without any adverse impact or penalty on their retirement entitlements, at the retirement age of 60 or 62, which has remained unchanged in the rules of the United Nations Joint Staff Pension Fund.

38. As a result, the proposed amendment provides that all staff members separate at the age of 65 unless those who joined the United Nations Joint Staff Pension Fund before 1 January 2014 decide to exercise their acquired right and elect to retire earlier, on their retirement age or between their retirement age and the age of 65.

39. It should be noted that the Commission's recommendation to extend the mandatory age of separation to 65 for serving staff was not prompted primarily by concerns about the sustainability of the United Nations Joint Staff Pension Fund, unlike the extension of age of retirement in national pension systems: because the United Nations Joint Staff Pension Fund is in a sound financial position, and has a positive actuarial status, the age of retirement for participants who joined before 1 January 2014 has remained unchanged and is to be preserved "taking into account the acquired rights of staff".

[1] See http://icsc.un.org/resources/pdfs/ar/AR2012.pdf (accessed 1 November 2016).

[2] See resolution EB133.R3 (2013).

40. Rather, it has been argued that given the longer life expectancy trends and as the Secretariat extends the appointment of staff members beyond retirement age and rehires former staff members who have retired, it would be fairer to extend the appointment of all staff up to the age of 65. Data show that extensions beyond retirement age have been granted by the Director-General in accordance with Staff Regulation 9.5, in the interests of the Organization on rare occasions and on an exceptional basis. These extensions are normally for short periods, from a few months to one year.[1] They are usually granted to senior staff in order for them to complete an important project, or to coincide with the end of term of an outgoing Director-General or Regional Director. Exceptionally, appointments of staff members have been extended beyond retirement age when the recruitment of a successor has been delayed, due to lack of suitable candidates and pending the completion of the selection process.

41. Of the total number of WHO staff who retired between 2011 and 2016 (911), of which 45% were from the professional and higher categories, only 12% had their appointments exceptionally extended beyond retirement age in the interests of the Organization. Of those, 79% were from the professional and higher categories. The extensions were for a period of between one and 12 months in 80% of the cases; between one year and less than three years in 18% of the cases; and for a total of three years or more in 2% of the cases.

42. The extension of the mandatory age of separation to 65 for serving staff will allow all staff members, whether they are in the international professional category, the national professional category or the general service category, to stay up to three years (if their retirement age is 62) or up to five years (if their retirement age is 60) longer.

43. Like the other United Nations agencies, WHO hires retired staff for specific, time-bound activities, often for senior expertise contributions or for emergency/surge work. However, WHO being committed to the career development of serving staff members, the recruitment of retirees has restrictions: contracts are of limited duration, a remuneration ceiling is applied, the proposed recruitment is authorized only when it does not adversely affect the career development opportunities of serving staff members or the recruitment of new staff, and the recruitment represents both a cost-effective and operationally sound solution to meet the needs of the Organization. Compared to the number of international professional, national professional and general service staff who have retired from WHO (currently close to 6000 former WHO staff members are in receipt of pension benefits from the United Nations Joint Staff Pension Fund), the number of retirees who are rehired is very limited.

44. The implementation of resolution 70/244 will actually have the effect of reversing the decision-making: currently, the Director-General decides who among the staff members who reach retirement age should have their appointments extended in the interests of the Organization, and for how long. With the increase of the mandatory age of separation to 65 “taking into account the acquired rights of staff”, it will be for the staff members to decide when to retire: the Director-General will have no authority to oblige a staff member to retire at the initial age of retirement, except through a costly termination of appointment. This fundamental shift was noted by some Commission members who, as reflected in the Commission’s report for 2014, “expressed the view that the organizations should have flexibility in employing staff up to the proposed higher mandatory age of separation by taking into account their performance and restructuring needs (abolition of posts, downgrading of posts). To give the possibility of choice solely to the staff member without flexibility for the organization would not

[1] Staff Rule 1020.1 specifies that exceptional extensions cannot be granted for more than one year at a time.

be a balanced solution".[1] However, this opinion was not reflected in the Commission's recommendation on the matter to the United Nations General Assembly.

Implications of the amendments

45. **Succession planning.** As requested by Member States, the Secretariat has been conducting annual succession planning exercises through which the Organization can plan one year in advance what will be done with the posts vacated by staff members retiring the following year. The posts may be abolished, replaced by posts with new profiles, or downgraded, all of which would allow the Organization to take an agile approach towards aligning its human resources plans with its new priorities.

46. Because staff members who joined the United Nations Joint Staff Pension Fund before 1 January 2014 will be able to choose when to retire (between the ages of 60 or 62 and 65), the Secretariat will no longer be in a position to anticipate the retirement of its staff members at 60 or 62. Even if they are asked to inform the Secretariat of their elected retirement date at least one year in advance, staff members may, by giving three months' notice, retire earlier than they had initially indicated, or decide to stay longer than they had initially indicated, as long as they do not stay beyond the age of 65.

47. **Gender balance and geographical representation.** The natural attrition of staff has been seen as an opportunity to improve gender balance and geographical representation.

48. Since 2010, improvements in gender balance have been recognized; progress, however, is slow. It took approximately five years to increase the percentage of women in the professional and higher categories by 2%; the current target is to increase this percentage by 3% (55:45) over two years. As at 31 July 2016, 42.8% of the current long-term staff members in the professional and higher categories are female.

49. As at 31 July 2016, 34% of WHO Member States continue to be either unrepresented or under-represented in the international professional staff category (in which positions are counted for geographical representation). The target in the Programme budget 2016–2017 is to reduce this figure to 28%.

50. These data show that further efforts must be made to improve gender balance and geographical representation at all grades. To that effect, female staff members and staff members from under- or non-represented countries in the internal talent pool have to be given opportunities to get higher-level positions. However, gender balance and equitable geographical representation can be achieved only through the intake of newcomers. In other words, the Organization must hire external candidates to positions newly created subject to the availability of funding and to positions vacated by separating staff, particularly by staff retiring when they reach retirement age.

51. Looking ahead to the biennium 2018–2019,[2] under the current mandatory age of separation, 182 staff members would have been due to retire in 2018 and 187 in 2019, accounting for 5.9% of the total number of staff members. Of these, 51% in 2018 and 42% in 2019 belong to the professional and higher categories. Of the staff members in these categories who would have been due to retire, 66% in

[1] Official Records of the General Assembly, Sixty-ninth session (document A/69/30, para. 107).

[2] See Table 8 of the document entitled "Human resources: update, Workforce data as at 31 July 2016" at: http://www.who.int/about/finances-accountability/budget/en/ (accessed 1 November 2016).

2018 and 64% in 2019 are male, and 64% in 2018 and 59% in 2019 are from over-represented countries.

52. The improvement of gender balance and geographical representation will inevitably slow down when, as the result of the mandatory age of separation of serving staff being extended to 65, staff who would have otherwise retired at the age of 60 or 62 decide to stay up to the age of 65.

53. **Financial implications.** In its report for the year 2014,[1] the Commission, in making its recommendation to the United Nations General Assembly, noted that increasing the mandatory age of separation to 65 for serving staff will have the positive effect of containing after-service health insurance liabilities; in other words, keeping staff active for longer would not entail a liability for after-service health insurance. As far as WHO is concerned, the impacts on the Organization's long-term estimated liability, and financing, for after-service health insurance are difficult to estimate. On the one hand, there is a positive impact since staff working an extra three or five years will provide additional contributions to the scheme (two thirds of which are a cost to WHO, one third of which is paid by staff). On the other hand, some staff who joined WHO late in their career (for example, at the age of 53, 54 or 55) and who would not have reached the 10-year minimum service period for eligibility to the scheme, will now become eligible, with a resulting negative financial impact. The actual impacts will depend on which staff members choose to extend their age of retirement to 65, and their prior service period in the Organization. The situation will be assessed by independent actuaries, who will make assumptions on these and other variables that have an impact on after-service health insurance.

54. A similar situation may exist for the pension fund liability and revenue stream, with additional pension payouts as a result of longer service offsetting additional income arising from the pension contributions payable for an additional three years, again funded one third by staff, and two thirds by WHO.

55. The extension of the mandatory age of retirement to 65 for serving staff will also have budgetary implications in terms of delaying a more cost-effective realignment of the WHO staffing structure. The annual succession planning exercises show that in 2014, 2015 and 2016, 12.8% of the posts encumbered by retiring staff were planned for abolition. With the possibility that current staff may stay until the age of 65, the Organization will either keep the staff members on positions that otherwise would have been abolished had they retired, or, if the positions are nonetheless abolished, pay them the expensive entitlements (such as reassignment period, notice period and termination indemnity) to which they would have not been entitled had they retired at the age of 60 or 62. This will be the case for staff working for the Global Polio Eradication Initiative who would have otherwise retired during the period of closure of the initiative. With respect to termination indemnity, Staff Rule 1050 (Abolition of post) is amended to clarify that staff members are not paid a termination indemnity on retirement or beyond their retirement date as defined by the United Nations Joint Staff Pension Fund (Staff Rule 375 on the end-of-service grant has minor editorial changes also related to retirement).

56. There will also be implications in respect of the rejuvenation of the workforce. Many of the positions currently occupied by staff due to retire in 2018 and the following years could be downgraded and would thereby create additional, more cost-effective, opportunities for recruitment at more junior levels.

[1] See http://icsc.un.org/resources/pdfs/ar/AR2014.pdf (accessed 1 November 2016).

ACTION BY THE EXECUTIVE BOARD

57. [This paragraph contained three draft resolutions, two of which were adopted at the seventeenth meeting as resolutions EB140.R8, and EB140.R9, respectively. Consideration of the remaining draft resolution was deferred by the Board to its 141st session.][1]

[1] See document EB140/2017/REC/2, summary records of the seventeenth meeting, section 3.

Appendix 1

TEXT OF AMENDED STAFF RULES

310. DEFINITIONS

……

310.5.2 a child as defined by the Director-General and for whom the staff member certifies that he provides the main and continuing support, provided that the child is under 18 years of age or, if in full-time attendance at a school or university, under the age of 21 years. Age and school attendance requirements shall not apply if the child is physically or mentally incapacitated for substantial gainful employment either permanently or for a period expected to be of long duration. If both parents are staff members of international organizations applying the common system of salaries and allowances, the children, if determined dependent, will be recognized as the dependants of the parent whose annual gross occupational earnings yield the higher amount, unless the staff members concerned request otherwise;

…

310.7 A "single parent" is a staff member who meets the following criteria:

310.7.1 The staff member does not have a spouse;

310.7.2 The staff member has a dependent child as defined under Staff Rule 310.5.2;

310.7.3 The staff member provides main and continuing support to the child.

……

315. RECRUITMENT INCENTIVE

An incentive payment for the recruitment of experts in highly specialized fields in instances in which the Organization is unable to attract suitably qualified personnel may be made at the discretion of the Director-General. The amount of the recruitment incentive shall not exceed 25% of the annual net base salary for each year of the initial appointment.

……

330. SALARIES

330.1 Gross base salaries shall be subject to the following assessments:

330.1.1 For professional and higher graded staff:

Assessable income US$	Staff assessment rates
	%
First 50 000	17
Next 50 000	24
Next 50 000	30
Remaining assessable payments	34

……

340. DEPENDANTS' ALLOWANCES

Staff members appointed to the professional or higher categories, are entitled to dependants' allowances pursuant to the definitions provided in Staff Rules 310.5 and 310.7, as follows:

340.1 for a dependent child, the entitlement shall be reduced by the amount of any benefit paid from any other public source by way of social security payments, or under public law, by reason of such child.

340.2 for a child who is physically or mentally disabled, an amount equivalent to double the dependent child allowance, subject to the conditions defined in Staff Rule 340.1.

340.3 for a father, mother, brother or sister.

340.4 for a dependent spouse.

340.5 for being recognized as having the status of a single parent.

340.6 The allowances to be paid under Staff Rules 340.1, 340.2, 340.3, 340.4 and 340.35 shall be as determined by the Director-General on the basis of procedures agreed among the international organizations concerned established by the International Civil Service Commission.

……

350. EDUCATION GRANT

…

350.1.1 the grant is payable for each child as defined under Staff Rule 310.5.2 up to the end of the school year in which the child reaches the age of 25, completes four years of post-secondary studies or attains a first post-secondary degree, whichever is earlier;

…

350.2 This grant is payable for:

…

350.2.2 the cost of full-time attendance at an educational institution outside the country or area of the duty station. For staff members assigned outside category H duty stations, an additional lump sum for boarding-related expenses for primary and secondary levels only is also payable;

…

350.4 "Cost of attendance" is defined as the cost of tuition , including mother tongue tuition, and enrolment-related fees only.

…

350.6 Capital assessment fees charged by educational institutions shall be reimbursed under conditions prescribed by the Director-General outside the education grant scheme.

……

360. MOBILITY INCENTIVE, HARDSHIP ALLOWANCE AND NON-FAMILY SERVICE ALLOWANCE

360.1 The following staff members shall receive a non-pensionable allowance designed to provide incentives for mobility, recognize varying degrees of hardship at different duty stations, and provide non-family service allowance for service in duty stations with family restrictions. These allowances are determined by the Director-General on the basis of conditions and procedures established by the International Civil Service Commission:

360.1.1 staff members, except those appointed under Staff Rules 1310 and 1330, who are appointed or reassigned to designated categories of duty stations as determined by the International Civil Service Commission, for a period of one year or longer, and

360.1.2 staff members, except those appointed under Staff Rules 1310 and 1330, who are appointed or reassigned to designated categories of duty stations as determined by the International Civil Service Commission, for an initial period of less than one year, and whose appointment or reassignment is subsequently extended so that the uninterrupted period of service at that duty station is one year or longer.

360.2 [Deleted]

360.3 Duty stations shall be categorized according to conditions of life and work and on the basis of criteria established by the International Civil Service Commission for classifying duty stations.

360.4 Staff members who are assigned to duty stations for which family restrictions have been declared by the International Civil Service Commission shall be paid the non-family service allowance as determined by the Director-General.

……

365. SETTLING-IN GRANT

365.1 A staff member whose travel is authorized shall be paid a settling-in grant:

365.1.1 upon appointment or upon reassignment to a duty station for a period of at least one year; or

365.1.2 upon extension of an initial appointment or reassignment to a duty station of less than one year, resulting in an uninterrupted period of service of one year or longer at the same duty station.

365.2 The amount of the settling-in grant shall be the equivalent of the applicable per diem at the date of arrival at the duty station:

365.2.1 for the staff member for a period of 30 days;

365.2.2 for the spouse and/or dependent child(ren) accompanying or joining the staff member at the Organization's expense under Staff Rule 820, for 15 days.

365.3 Subject to conditions established by the Director-General on the basis of conditions and procedures agreed among international organizations in the United Nations common system, the settling-in grant shall also include a lump sum calculated and payable on the basis of one month of the staff member's net base salary and, as applicable, the post adjustment at the duty station to which the staff member is assigned and at the rate applicable at the date of arrival at the duty station.

365.4 No settling-in grant shall be paid for children born, or for any other dependant acquired, after the arrival of the staff member at the duty station.

365.5 If a staff member resigns from the Organization within one year of the date of his or her appointment or reassignment to a duty station, the lump sum portion of the settling-in grant paid under Staff Rule 365.3 is recoverable proportionately under conditions established by the Director-General.

……

370. REPATRIATION GRANT

370.1 A staff member who on leaving the service of the Organization, other than by summary dismissal under Staff Rule 1075.2, has performed at least five years of continuous service outside the country of his recognized place of residence shall be entitled to a repatriation grant. This grant is payable in accordance with the following schedules and with Staff Rule 380.2. Payment in respect of entitlements shall be subject to receipt from the former staff member of documentary evidence, in accordance with criteria established by the Director-General, of relocation outside the country of the staff member's last duty station or residence during the last assignment, with due regard to the provisions of Staff

Rule 370.4. This part of the grant is payable if it is claimed within two years of the effective date of separation.

370.1.1 For staff members of the professional and higher categories:

Year of qualifying service	Weeks of salary	
	Without spouse or dependent children	With spouse or dependent children
5	8	14
6	9	16
7	10	18
8	11	20
9	13	22
10	14	24
11	15	26
12 or more	16	28

370.1.2 For staff members of the general service category:

Year of qualifying service	Weeks of salary	
	Without spouse or dependent children	With spouse or dependent children
5	7	14
6	8	16
7	9	18
8	10	20
9	11	22
10	12	24
11	13	26
12 or more	14	28

……

375. END-OF-SERVICE GRANT

Staff members holding a fixed-term appointment whose appointment is not renewed after completing five years of continuous qualifying service, and whose performance has been certified as being satisfactory, shall be entitled to a grant based on the years of service, unless an offer of renewal of appointment has been either received or declined or the staff member has reached the age of retirement as defined under Staff Rule 1020.1. The amount of the grant shall be fixed according to the schedule in Staff Rule 1050.10 for termination of fixed-term appointments.

……

410. RECRUITMENT POLICIES

…

410.2 Candidates under 20 or over 65 years of age shall not normally be considered for appointment.

……

510. ASSIGNMENT TO DUTY

…

510.2 An assignment for the purpose of entitlement to settling-in grant, mobility incentive and relocation shipment is an assignment requiring the installation of the staff member in the duty station for a period of at least one year.

……

550. WITHIN-GRADE INCREASE

…

550.2 The unit of service time is defined as the minimum length of time which must be served at a step in order to achieve a within-grade increase under the terms of Staff Rule 550.1. The unit of service time is as follows:

550.2.1 one year of full-time service at all levels and steps except at those in Staff Rule 550.2.2;

550.2.2 two years of full-time service for grades P-1 to P-5 from step VII, for P-6/D-1 from step IV, and for D-2 from step I;

…

550.3 [Deleted]

……

640. HOME LEAVE

…

640.2 The date of eligibility for home leave shall be the date on which the staff member has completed 24 months or 12 months of qualifying service, depending on the category of the duty station as established by the International Civil Service Commission. The date may be determined according to criteria established by the Director-General in cases of reassignment or reclassification of duty stations. All duty stations are classified for this purpose, according to their home leave cycle, as “24-month stations” or “12-month stations”.

……

810. TRAVEL OF STAFF MEMBERS

The Organization shall pay the travel expenses of staff members as follows:

…

810.5 on family visit, once between home leave eligibility dates (or once during an appointment of equivalent duration) as set out in Staff Rule 640.2 from the duty station to the place where the staff member's spouse and children, as defined in Staff Rule 820.1, are residing, and return to the duty station, provided that:

810.5.1 the staff member has waived his entitlements to the travel of his spouse and children under Staff Rules 820 and 825, except for education grant travel under Staff Rule 820.2.5.2;

……

820. TRAVEL OF SPOUSE AND CHILDREN

820.1 Family members recognized as eligible for purposes of travel at the Organization's expense are:

…

820.1.3 each such child for whom travel expenses have previously been paid by the Organization, to the extent of the final one-way passage either to join the staff member at the official station or to return to the country of the recognized place of residence within one year after ceasing to qualify as a dependant. The Organization's financial responsibility shall be limited to the cost of one-way travel between the official station and the recognized place of residence. However, if a round trip to which the child may be entitled under Staff Rule 820.2.5.2 is completed after the end of the scholastic year in which the child reaches the age of 21, this travel shall not be authorized;

820.1.4 a child entitled to the education grant under Rule 310.5.2, for purposes of travel under Staff Rules 820.2.5.1, 820.2.5.2 and 820.2.5.5.

…

820.2 The Organization shall pay the travel expenses of a staff member's spouse and dependent children, as defined in Staff Rule 820.1, under the following circumstances:

820.2.1 on appointment for a period of not less than one year, or upon extension of an initial appointment of less than one year resulting in an uninterrupted period of service of one year or longer, from the recognized place of residence or, at the option of the Organization, the place of recruitment, to the duty station, or from some other place, provided that the cost to the Organization does not exceed that for the travel from the recognized place of residence, and subject to the requirement that in any case the spouse is expected to remain at the duty station at least six months;

…

820.2.5 for a child for whom there is an entitlement to boarding assistance under an education grant in accordance with Staff Rule 350, provided Staff Rule 655.3 does not apply:

…

820.2.5.3 [Deleted]

…

820.2.5.5 the final one-way passage defined in Staff Rule 820.1.3 within one year after ceasing to qualify for education grant under Staff Rule 350.1.2, provided that such entitlement has not already been exercised under Staff Rule 820.1.3. The Organization's financial responsibility shall be limited to the cost of one-way travel between the official station and the recognized place of residence. However, if a round trip to which the child may be entitled under Staff Rules 820.2.5.2 is completed after the child ceases to qualify for an education grant under Staff Rule 350.1.2, this travel shall not be authorized;

……

855. RELOCATION SHIPMENT

855.1 On an assignment (see Rule 510.2.), a staff member appointed or reassigned for a period of at least one year, or separated, except as provided in Staff Rule 1010.2, and whose recognized place of residence is other than and not in the area of the duty station, shall be entitled to reimbursement, within limits established by the Director-General, for the expense of moving household goods.

855.2 If both spouses are staff members of international organizations applying the common system of salaries and allowances and each is entitled to reimbursement for the expense of moving household goods, each shall have the choice of exercising the entitlement within limits established by the Director-General.

……

860. FAILURE TO EXERCISE ENTITLEMENT

Any entitlement to repatriation travel or relocation shipment must be exercised within two years of the date of separation.

……

870. EXPENSES ON DEATH

…

870.2 A deceased staff member's spouse and child(ren) shall be entitled to travel and relocation shipment to any place, provided that the Organization had an obligation to repatriate them under Staff Rule 820.2.7 and that the cost to the Organization does not exceed that for travel and transportation to the deceased staff member's recognized place of residence. Entitlement to relocation shipment is determined by Staff Rule 855.1.2.

……

1020. RETIREMENT

1020.1 Staff members shall retire on the last day of the month in which they reach the age of 65, unless Staff Rule 1020.1.1, 1020.1.2 or 1020.1.3 applies.

1020.1.1 Staff members who became participants in the United Nations Joint Staff Pension Fund before 1 January 1990 may elect to retire on the last day of the month in which they reach the age of 60, or between the ages of 60 and 65, by giving at least three months' written notice of the elected date of retirement.

1020.1.2 Staff members who became participants in the United Nations Joint Staff Pension Fund from 1 January 1990 to 31 December 2013 inclusive may elect to retire on the last day of the month in which they reach the age of 62, or between the ages of 62 and 65, by giving at least three months' written notice of the elected date of retirement.

1020.1.3 Staff members shall not change their elected date of retirement once they have given their three months' notice under Staff Rules 1020.1.1 or 1020.1.2.

1020.1.4 In exceptional circumstances the Director-General may, in the interests of the Organization, extend a staff member's appointment beyond the age of 65, provided that such extensions shall not be granted for more than one year at a time and not beyond the staff member's sixty-eighth birthday.

……

1050. ABOLITION OF POST

1050.10 Subject to Staff Rules 1050.11 and 1050. 12, staff members whose appointments are terminated or not extended under this Rule shall be paid an indemnity in accordance with the following schedule and with due regard to Staff Rule 380.2:

…

1050.11 An indemnity shall not be paid to any staff member who, upon separation from service, will receive a retirement benefit under Article 28 of the Regulations of the United Nations Joint Staff Pension Fund.

1050.12 An indemnity which exceeds the number of months remaining until a staff member will receive a retirement benefit under Article 28 of the Regulations of the United Nations Joint Staff Pension Fund shall be made pro rata to the first day of the month upon which a staff member will receive such a retirement benefit.

Appendix 2

Appendix 1 to the Staff Rules

SALARY SCALE FOR THE PROFESSIONAL AND HIGHER CATEGORIES: ANNUAL GROSS SALARIES AND NET EQUIVALENTS AFTER APPLICATION OF STAFF ASSESSMENT (IN UNITED STATES DOLLARS)

(effective 1 January 2017)

Step

Level		*I*	*II*	*III*	*IV*	*V*	*VI*	*VII*	*VIII*	*IX*	*X*	*XI*	*XII*	*XIII*
		*	*	*	*	*	*	*	*	*	*			
D-2	**Gross**	**139 500**	**142 544**	**145 589**	**148 637**	**151 788**	**155 018**	**158 248**	**161 479**	**164 709**	**167 939**			
	Net	107 150	109 281	111 412	113 546	115 680	117 812	119 944	122 076	124 208	126 340			
					*	*	*	*	*	*	*	*	*	*
D-1	**Gross**	**124 807**	**127 483**	**130 160**	**132 837**	**135 506**	**138 183**	**140 857**	**143 529**	**146 207**	**148 880**	**151 648**	**154 483**	**157 320**
	Net	96 865	98 738	100 612	102 486	104 354	106 228	108 100	109 970	111 845	113 716	115 588	117 459	119 331
								*	*	*	*	*	*	*
P-5	**Gross**	**107 459**	**109 734**	**112 011**	**114 284**	**116 561**	**118 834**	**121 113**	**123 387**	**125 663**	**127 937**	**130 214**	**132 486**	**134 764**
	Net	84 721	86 314	87 908	89 499	91 093	92 684	94 279	95 871	97 464	99 056	100 650	102 240	103 835
								*	*	*	*	*	*	*
P-4	**Gross**	**88 351**	**90 374**	**92 396**	**94 418**	**96 441**	**98 462**	**100 529**	**102 724**	**104 919**	**107 114**	**109 314**	**111 504**	**113 701**
	Net	70 647	72 184	73 721	75 258	76 795	78 331	79 870	81 407	82 943	84 480	86 020	87 553	89 091
								*	*	*	*	*	*	*
P-3	**Gross**	**72 478**	**74 349**	**76 221**	**78 091**	**79 964**	**81 836**	**83 707**	**85 582**	**87 451**	**89 324**	**91 199**	**93 068**	**94 942**
	Net	58 583	60 005	61 428	62 849	64 273	65 695	67 117	68 542	69 963	71 386	72 811	74 232	75 656
								*	*	*	*	*	*	*
P-2	**Gross**	**55 955**	**57 629**	**59 303**	**60 976**	**62 651**	**64 328**	**66 003**	**67 674**	**69 350**	**71 022**	**72 696**	**74 374**	**76 045**
	Net	46 026	47 298	48 570	49 842	51 115	52 389	53 662	54 932	56 206	57 477	58 749	60 024	61 294
								*	*	*	*	*	*	*
P-1	**Gross**	**43 371**	**44 672**	**45 973**	**47 275**	**48 575**	**49 877**	**51 287**	**52 708**	**54 129**	**55 551**	**56 971**	**58 391**	**59 812**
	Net	35 998	37 078	38 158	39 238	40 317	41 398	42 478	43 558	44 638	45 719	46 798	47 877	48 957

* = The normal qualifying period for a within-grade increase between consecutive steps is one year, except at those steps marked with an asterisk, for which a two-year period at the step is required to proceed to the next step (Staff Rule 550.2).

Appendix 3

Appendix 2 to the Staff Rules

EDUCATION GRANT

EDUCATION GRANT SCALE, ADJUSTED ON THE BASIS OF 2014/15 TUITION FEES

(effective school year in progress 1 January 2018)

Claim amount bracket (United States dollars)	**Reimbursement rate** (percentage)
0 – 11 600	86
11 601 – 17 400	81
17 401 – 23 200	76
23 201 – 29 000	71
29 001 – 34 800	66
34 801 – 40 600	61
40 601 and above	–

ANNEX 3

Post of Director-General: options for the conduct of the election on the basis of paper-based voting[1]

[EB140/4 – 23 December 2016]

1. This report provides information on the use of a paper-based voting system for the conduct of the election of the Director-General and presents options for the conduct of paper-based voting in both the Executive Board and the Health Assembly in order to improve the efficiency and speed of the process. Further information is also provided on the modalities of the conduct of the voting and of the interviews of shortlisted candidates in the Board.

I. USE OF A PAPER-BASED VOTING SYSTEM IN THE EXECUTIVE BOARD AND THE HEALTH ASSEMBLY

2. The Health Assembly, in resolution WHA67.2 (2014), on improved decision-making by the governing bodies, approved the recommendation of the Executive Board to rent a cost-effective and secure electronic voting system for the nomination and appointment of the Director-General, and to test such a system in advance through mock votes by the governing bodies before the election of the next Director-General.

3. The Secretariat investigated the availability of electronic voting systems and rented two systems. These were tested through a simulation exercise during both the 138th session of the Executive Board and the Sixty-ninth World Health Assembly, respectively. The first system, tested during the 138th session of the Executive Board, was rejected because it was difficult to use and testing revealed an unacceptable risk of null and void votes. The second system was tested at the Sixty-ninth World Health Assembly. It met the requirements for ease of use but the Secretariat indicated at that time that a security review would need to be carried out before a final decision to use the system could be taken.

4. An external security review of the second system conducted immediately following the Sixty-ninth World Health Assembly found that the system was insufficiently secure. It was also found that a suitable alternative electronic voting system could not be deployed in time for the election of the Director-General in 2017. As a consequence, the review concluded that the use of paper voting was the only feasible way forward for the upcoming election. It should further be noted that the review also recommended that the Rules of Procedure be reviewed and amended as necessary in order to adapt them more specifically to the use of an electronic voting system for the election of the Director-General in the future.

[1] See decisions EB140(1) and EB140(2).

5. One of the prime rationales for the Health Assembly's approval in resolution WHA67.2 of the idea of exploring the use of electronic voting was to save time in the conduct of voting. Accordingly, the Secretariat has drawn up an operational plan for implementing paper-based voting, with a view to proposing measures that reduce the time required for the conduct of each round of voting in a paper-based process.

6. This report makes proposals for time-saving measures in the conduct of voting at both the Board and the Health Assembly. The proposals concern the three most time-intensive stages of paper-based voting in WHO's governing bodies (distribution of ballot papers, collection of ballot papers, and counting of the votes).

7. The Board may accordingly wish to decide that paper-based voting will be used for the nomination of the Director-General. The Board may further wish to recommend to the Seventieth World Health Assembly the use of paper-based voting for the appointment of the Director-General.

II. OPTIONS FOR IMPROVING THE EFFICIENCY OF PAPER-BASED VOTING IN THE BOARD

8. Based on past experiences, the Secretariat estimates one round of voting in the Board to require a relatively short period of time, namely between 30 and 60 minutes. It is therefore proposed to conduct the distribution, collection and counting of ballot papers in the Board largely as in the past.

9. In order to save time, members of Board will find "voting shields" intended to guarantee the secrecy of the vote already set up on their tables at the outset of meetings at which voting is scheduled to take place.

10. The Secretariat proposes to use two ballot boxes instead of one to collect ballot papers from members of the Board at the close of voting.

11. Implementation of these proposals would not require any amendment to the Rules of Procedure of the Executive Board.

III. OPTIONS FOR IMPROVING THE EFFICIENCY OF PAPER-BASED VOTING IN THE HEALTH ASSEMBLY

12. Based on past experiences, the Secretariat estimates that one round of voting at the Health Assembly requires up to one full morning or afternoon meeting of the Health Assembly if the traditional process prescribed by the Rules of Procedure of the World Health Assembly and Health Assembly's Guiding Principles for the Conduct of Elections by Secret Ballot is followed in May 2017.

13. The Secretariat therefore proposes the time-saving measures described in the Table. Based on tests that have been conducted by the Secretariat, implementation of these measures could reduce the time required to conduct one round of voting at the Health Assembly to about 80 minutes per round.

14. Implementation of the measures in the Table will require minor adjustments by the Health Assembly to the Rules of Procedure of the World Health Assembly and the Guiding Principles for the Conduct of Elections by Secret Ballot. These adjustments may be given effect by a partial suspension or amendment of applicable rules as set out in the right-hand column of the Table. If the Board wishes to recommend that the measures be implemented only for the appointment at the Seventieth World Health Assembly, a partial suspension of the relevant rules should be proposed in accordance with Rule 120 of the Rules of Procedure of the World Health Assembly; otherwise the amendments set out

in the [Appendix] should be proposed in accordance with Rule 119 of the Rules of Procedure of the World Health Assembly.

Table. Proposals for time-saving measures for paper-based voting in the Health Assembly and consequent requirements for amendment or suspension of the Guiding Principles or Rules of Procedure of the World Health Assembly

Proposal		Is amendment or suspension of a Guiding Principle or Rule of Procedure of the World Health Assembly required?
(1)	Delegations are called to vote simultaneously at six voting stations set up in front of each of the six seating blocks in the Assembly Hall at the Palais des Nations. Delegations are called to vote in the order they are seated in the six seating blocks.	Yes. The Guiding Principles for the Conduct of Elections by Secret Ballot require that members shall be called in turn to vote in the required alphabetical order of their names, beginning with the name of a Member which shall have been drawn by lot and that the call shall be made in English, French, Russian and Spanish.
(2)	One teller and one legal officer are positioned at each of the six voting stations. The legal officer distributes one ballot paper to each representative having come to the voting station at which he/she is positioned and records the distribution of a ballot paper to the respective delegation on a sheet of paper.	Yes. Rule 78 of the Rules of Procedure of the World Health Assembly provides that, where a ballot is required, two tellers appointed by the President from among the delegations present shall assist in the counting of votes. The Guiding Principles for the Conduct of Elections by Secret Ballot refer to the ballot box in the singular throughout.
(3)	After each Member entitled to vote has inserted its ballot paper in the ballot box, the six tellers positioned at the voting stations carry the ballot boxes to the rostrum and place them on three tables. At each table, two tellers will then open the two ballot boxes placed on each table, count the votes and record the result on a sheet prepared for this purpose by the Secretariat.	Yes. As for (2) above.
(4)	One teller at each table carry the result sheet to a fourth table where the result of the vote will be recorded onto the appropriate WHO form.	Yes. As for (2) above.

IV. MODALITIES OF THE CONDUCT OF THE VOTING IN THE EXECUTIVE BOARD

15. Meetings of the Board related to the nomination of the Director-General are convened as “open meetings” in accordance with Rule 7(b) of the Rules of Procedure of the Executive Board.

Accordingly, attendance will be open to: members of the Board, their alternates and advisers; one representative of each Member State not represented on the Board and of each Associate Member; and the Secretariat. Representatives of Member States not represented on the Board and of Associate Members attend without the right to participate. No official record is made.

16. The modalities of the conduct of the voting during the short-listing and nomination phases are set out below. For further information on the majorities required at each stage and other legal issues please refer to document EB140/INF./1.

17. It is expected that candidates will be shortlisted on Tuesday, 24 January 2017 and the nomination will take place on Wednesday, 25 January 2017 after completion of the interviews. In line with previous practice, the Board may wish to decide in principle to meet in continuous session, without breaking between rounds of voting in the event that there is more than one round.

18. Members of the Executive Board will find voting shields already set up on their tables at the outset of meetings at which voting is scheduled to take place.

19. After the opening of a meeting at which voting is scheduled, the Chairman will appoint two tellers from among the members of the Board present to assist with the procedure. The Chairman will proceed to explain, with the assistance of the Legal Counsel, the details of the procedure to establish the shortlist and nominate candidates based on applicable rules, resolutions and decisions as well as established practice.

20. Before formally commencing the vote, the Chairman will invite the Legal Counsel to verify that the voting boxes are empty and will ask the Secretariat to distribute one ballot paper to each member of the Board present. Upon signal of the Chairman, the voting will be opened.

21. In line with previous practice, the names of the candidates will be written in English alphabetical order on the ballot papers. Thus, it will only be necessary to place a mark, such as an "X" or "check" ("√"), in the boxes next to the names of the candidates for whom each member of the Board wishes to vote. Members wishing to abstain may leave the ballot paper blank or indicate the word "abstention". Any ballot paper on which more names than the number of places to be filled, namely five (in the first round of the short-listing phase) or three (in the nomination phase), are marked will be null and void. Any ballot paper on which fewer names than the number of places to be filled, namely five (in the first round of the short-listing phase) or three (in the nomination phase), are marked will likewise be null and void. Any ballot paper bearing a distinguishing mark, such as, for example, the name of the voter, will also be declared null and void. Should any member of the Board make a mistake, he or she should erase or cross out the mark made by mistake so that it is clear to the tellers that the ballot paper has been corrected and that it is equally clear which are the chosen candidates. If, during the voting, a new ballot paper is required, the delegation concerned is invited to raise its flag and request a new ballot paper, which will be printed by the Secretariat.

22. Members of the Board will have two minutes to complete their vote. The Chairman will make an announcement after one minute has expired. Any member expecting to require more time to finalize their vote at this stage should signal this to the Chairman when he makes his announcement. The Chairman will then leave the vote open as needed until all members present have had the possibility to vote.

23. Once the time announced has expired, the Chairman will give signal for voting to close. Ballot papers should be folded once when they are deposited in the box. The Secretariat will pass by each of the members with the ballot boxes so that they may deposit their ballot papers.

24. The tellers will be invited to come to the centre table to count the votes. After completion of the count, the Legal Counsel will deliver the voting record sheet to the Chairman. The Chairman will report the results of the secret ballot to the Board by reading the number of votes obtained by each candidate. The Chairman will announce which candidates received the majorities required by the applicable rules.

25. For each successive round of voting, new ballots will be printed upon the Chairman's instructions.

26. The Chairman will read out the names of the shortlisted and nominated candidates respectively, in English alphabetical order, before adjourning the open meeting and reconvening in a public meeting to announce the names.

V. MODALITIES OF THE CONDUCT OF THE INTERVIEWS OF SHORTLISTED CANDIDATES

27. As indicated in document EB140/INF./1, the shortlisted candidates will be interviewed by the Board "as soon as possible" after the short list is drawn up.[1] The day for the interviews will be fixed in consultation with the Chairman. It is expected that candidates will be interviewed on Wednesday, 25 January 2017. Each interview will last not more than 60 minutes and will be divided equally between (a) an oral presentation of the candidate's vision for the future priorities of the Organization, with an analysis of current problems facing it and suggestions as to how those should be addressed, and (b) a question and answer session.[2]

28. The detailed modalities of the interviews are decided by the Board during the open meeting, on the proposal of the Chairman. The following modalities have been followed on the last four occasions on which nominations have been undertaken by the Board, and it is expected that the Chairman will invite the Board to proceed on the same basis on this occasion.

(a) The order in which candidates are interviewed is drawn by lot during the open meeting at which the short list is determined, so that the candidates can be informed in advance.

(b) The Secretariat times the presentation by each candidate using a traffic light system. The light remains green for 25 minutes, turns to amber and then turns to red after the allotted 30 minutes have expired, at which point the Chairman requests the candidate to terminate his or her presentation.

(c) Candidates may not use electronic presentation tools, such as PowerPoint, for their presentations.

(d) Before the beginning of the presentation by each candidate, the Secretariat distributes to each Board member a paper on which the member may write one question for the candidate in any official language of the Board. The paper should also identify the member posing the question.

[1] Rule 52, seventh paragraph, of the Rules of Procedure of the Executive Board.

[2] Rule 52, eighth paragraph, of the Rules of Procedure of the Executive Board and decision EB100(7) (1997), paragraph 5.

(e) At the end of the presentation, the Secretariat collects the papers into a box and hands them to the Chairman. The Chairman draws a question at random and reads it to the candidate, disclosing which member is asking the question; the Chairman will be assisted by the Secretariat's interpreters, as necessary, in carrying out this task. The 30 minutes allotted for this part of the interview start running when the Chairman reads the first question.

(f) Candidates have up to three minutes to respond to each question.

(g) This part of the interview is also timed by traffic lights. One set of traffic lights times the 30 minutes; the light turns from green to amber after 25 minutes and to red upon expiry of the 30 minutes. The second set of traffic lights measures the time allotted for each question; the light turns on when the candidate begins his or her response, remains green for the entire three minutes, and turns red when the three minutes are up, at which point the Chairman will request the candidate to terminate his or her response to each question.

(h) The Chairman will ask as many questions as possible within the time allotted for the question-and-answer period. If there are not enough questions to fill the whole duration of the 30 minutes allotted, the candidate will have the possibility of delivering an additional presentation until the 30 minutes have been exhausted.

ACTION BY THE EXECUTIVE BOARD

29. [This paragraph contained two draft decisions, which were adopted at the second meeting as decisions EB140(1), and EB140(2), respectively.][1]

Appendix

PROPOSED AMENDMENTS TO THE RULES OF PROCEDURE OF THE WORLD HEALTH ASSEMBLY AND THE GUIDING PRINCIPLES FOR THE CONDUCT OF ELECTIONS BY SECRET BALLOT[2]

Current version of Rule 78 of the Rules of Procedure of the World Health Assembly	**Proposed amended version of Rule 78 of the Rules of Procedure of the World Health Assembly**
(…) Where a ballot is required, two tellers appointed by the President from among the delegations present shall assist in the counting of votes.	(…) Where a ballot is required, two **or more** tellers appointed by the President from among the delegations present shall assist in the counting of votes.

Current version of the Guiding Principles for the Conduct of Elections by Secret Ballot	**Proposed amended version of the Guiding Principles for the Conduct of Elections by Secret Ballot**
Principle no. 1. Before voting begins, the President shall hand to the two tellers appointed by him the list of Members entitled to vote and the list of candidates. (…)	Before voting begins, the President shall hand to the ~~two~~ tellers appointed by him the list of Members entitled to vote and the list of candidates. (…)

[1] See document EB140/2017/REC/2, summary records of the second meeting, section 2.

[2] No changes to the proposed amendments were made during the discussions of the Executive Board at its 140th session (see document EB140/2017/REC/2, summary record of the second meeting, section 2).

Principle no. 3. The tellers shall satisfy themselves that the ballot box is empty and, having locked it, shall hand the key to the President.	The tellers shall satisfy themselves that the ballot box **or ballot boxes** is**/are** empty and, having locked it**/them**, shall hand the key/**keys** to the President.
Principle no. 4. Members shall be called in turn to vote in the required alphabetical order of their names,[1] beginning with the name of a Member which shall have been drawn by lot. The call shall be made in English, French, Russian and Spanish.	**Except as otherwise determined by the Health Assembly,** Members shall be called in turn to vote in the required alphabetical order of their names,[1] beginning with the name of a Member which shall have been drawn by lot. The call shall be made in English, French, Russian and Spanish.
Principle no. 7. When the ballot box has been opened, the tellers shall count the number of ballot papers. If the number is not equal to that of the voters, the President shall declare the vote invalid and another ballot shall be held.	When the ballot box **or ballot boxes** has**/have** been opened, the tellers shall count the number of ballot papers. If the number is not equal to that of the voters, the President shall declare the vote invalid and another ballot shall be held.

[1] Under Rule 72 of the Rules of Procedure of the World Health Assembly.

ANNEX 4

Recommendations of the United Nations' High-Level Commission on Health Employment and Economic Growth[1]

[EB140/17 − 21 November 2016]

[Paragraphs 1−3 described the Committee's mandate, given to it by the United Nations General Assembly in resolution 70/183 (2015).]

THE COMMISSION'S RECOMMENDATIONS AND IMMEDIATE ACTIONS

4. In recognition of the impact of the health workforce on attainment of all the Sustainable Development Goals, commissioners were appointed from the education, employment, health, labour and foreign affairs sectors of governments and international organizations, and from health professional associations, trade unions, academia and civil society. An independent Expert Group and a joint secretariat of staff members from ILO, OECD and WHO consolidated the available evidence and enabled technical and online consultations with multiple constituencies, including five technical consultations with Member States and other relevant stakeholders, 149 online submissions and 17 background papers.

5. The Commission's report presents evidence from the health and social sector, taking economic and labour perspectives, highlighting its capacity as a crucial source of future jobs, particularly for women and young people. The Commission concludes that "to the extent that resources are wisely spent and the right policies and enablers are put in place, investment in education and job creation in the health and social sectors will make a critical positive contribution to inclusive economic growth."

6. The Commission puts forward six recommendations to transform the global health workforce so as to be able to meet the needs for achieving the Sustainable Development Goals, with focus on the following areas: job creation, gender and women's rights, education training and skills, health service delivery and organization, technology, and crises and humanitarian settings. An additional four recommendations, in the areas of financial and fiscal space, partnerships and cooperation, international migration, and data, information and accountability, are made to enable this transformation.

7. Stressing the need for urgency, the Commission identifies five immediate actions to be taken between October 2016 and March 2018. These include the adoption of a five-year implementation plan, enhanced accountability, accelerated and progressive implementation of national health workforce accounts, an international platform on health workers mobility, and the massive scale up of professional, technical and vocational training. A high-level ministerial meeting will be held in Geneva on 14 and 15 December 2016 to propose actions and launch a consultative process that can take these recommendations forward.

[1] See decision EB140(3).

LINKAGES TO EXISTING DECISIONS OF THE WORLD HEALTH ASSEMBLY, UNITED NATIONS GENERAL ASSEMBLY AND UNITED NATIONS SECURITY COUNCIL

8. The Commission's recommendations and immediate actions reinforce the pressure to implement WHO's global strategy on human resources for health and prior resolutions of the World Health Assembly related to human resources for health. They also call for further strengthening of the health workforce implicit within related Health Assembly resolutions on the International Health Regulations (2005) and those relating to humanitarian settings and public health emergencies. The Commission emphasizes the need to ensure the protection and safety of health workers, as called for by United Nations General Assembly resolution 69/132 (2014) and United Nations Security Council resolutions 2175 (2014) and 2286 (2016).

9. The Commission's recommendations and immediate actions align closely with WHO's priorities in support of universal health coverage, with specific links to integrated people-centred health services, meeting workforce requirements for preparedness and response to emergencies, demographic and epidemiological transitions (for example, ageing populations and the increasing importance of noncommunicable diseases), WHO's gender strategy and related area of work, and International Health Partnership for Universal Health Coverage 2030.

10. Through its recommendations and immediate actions the Commission aims to deliver gains across the 2030 Agenda for Sustainable Development, including those in particular towards Sustainable Development Goals 1 (End poverty in all its forms everywhere), 3 (Ensure healthy lives and promote well-being for all at all ages), 4 (Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all), 5 (Achieve gender equality and empower all women and girls) and 8 (Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all).

ACTION BY THE EXECUTIVE BOARD

11. [In this paragraph the Board was invited to note the report.]

ANNEX 5

Member State mechanism on substandard/ spurious/ falsely-labelled/falsified/counterfeit (SSFFC) medical products: working definitions[1]

[EB140/23, Annex – 10 January 2017]

Appendix 3

INTRODUCTION

1. At the fourth meeting of the Member State mechanism on SSFFC medical products held on 19 and 20 November 2015, the decision was taken[2] to establish a working group on refining the working definitions of SSFFC medical products,[3] based on those currently used by the WHO global surveillance and monitoring system. This decision followed comments received from Member States with reference to the working definitions document circulated on the MedNet platform in 2015, which have been consolidated in the present paper.

Scope

2. This working group seeks to achieve a simplified common global understanding and provide clarity of what is meant by the term "SSFFC medical product" to Member States and all other stakeholders; and to recommend a definition of what constitutes a SSFFC medical product to the fifth meeting of the Member State mechanism.

3. In this sense, in the terms of reference set out in resolution WHA65.19 (2012)[4] it was stated in the relevant footnote that "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. Previous discussions between Member States show that there would be a consensus among them to accept the use of the term "falsified" for the purposes of the work carried out within the Member State mechanism. Should consensus among Member States be achieved, the term "SSFFC" could, therefore, be replaced by that agreed by them.

4. It is not intended to propose, or affect in any way, national and/or regional legislation either in existence or that may be drafted in the future by Member States and/or regional organizations relating

[1] See decision EB140(6).

[2] See document A/MSM/4/10.

[3] A medical product is defined as a medicine, vaccine or in vitro diagnostic (paragraph 3 document A/SSFFC/WG/5) and it may also include medical devices at an appropriate time in the future.

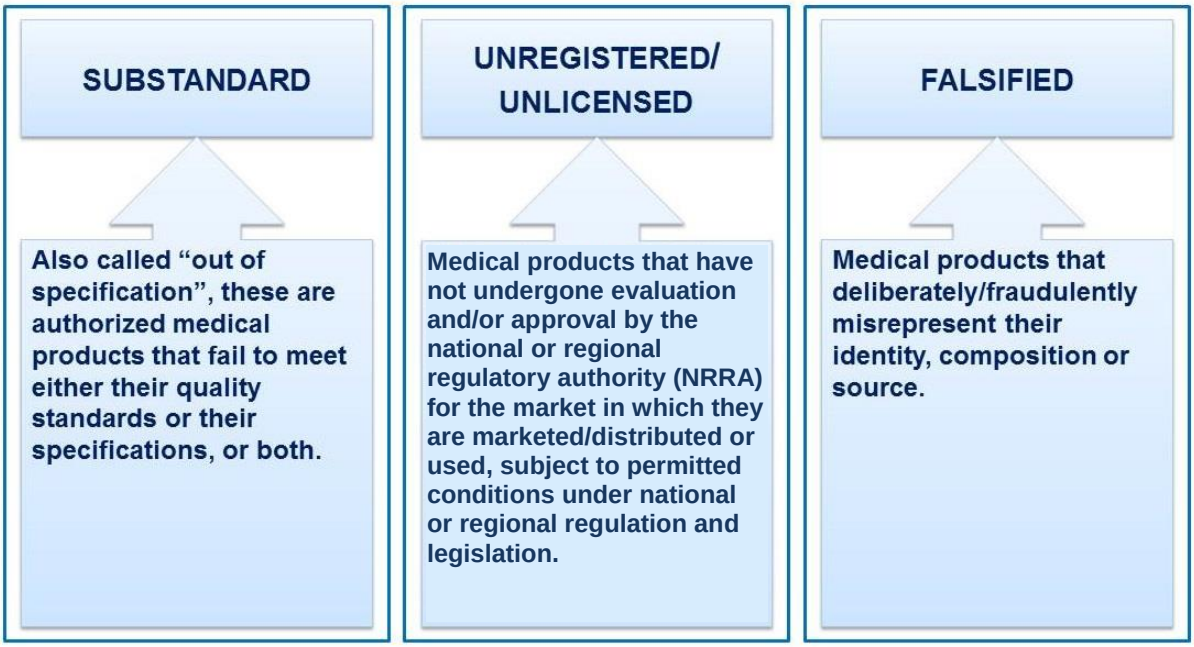
[4] See document WHA65/2012/REC/1.

to SSFFC medical products. No matter which terms are adopted by each Member State, it is important to have a clear understanding about the terms and their correlation with the working definitions adopted by the Member State mechanism.

Methodology

5. The classification of reports of SSFFC medical products to WHO permits a more thorough and accurate comparison and analysis of reports, separating substandard medical products from those that are deliberately/fraudulently making a misrepresentation (spurious, falsely-labelled, falsified or counterfeit) and those that are unregistered/unlicensed in the country of marketing (see Figure).

Figure. Classification of medical products to be used by the WHO global surveillance and monitoring system and the Member State mechanism



6. The classification table shown in the Figure above sets out three separate and mutually exclusive classifications of medical products reported to the WHO global surveillance and monitoring system.

7. For the purpose of this document and the classifications below, Authorized medical products means medical products in compliance with national and regional regulations and legislation. NRRAs can, according to national or regional regulations and legislation, permit the marketing or distribution of medical products with or without registration/licence.

(a) Substandard medical products

Also called "out of specification", these are authorized medical products that fail to meet either their quality standards or their specifications, or both[1]

[1] When the authorized manufacturer deliberately fails to meet these quality standards or specifications due to misrepresentation of identity, composition, or source, then the medical product should be considered "falsified".

(b) Unregistered/unlicensed medical products

Medical products that have not undergone evaluation and/or approval by the NRRA for the market in which they are marketed/distributed or used, subject to permitted conditions under national or regional regulation and legislation.

These medical products may or may not have obtained the relevant authorization from the national/regional regulatory authority of its geographical origin.

(c) Falsified medical products

Medical products that deliberately/fraudulently misrepresent their identity, composition or source.

Any consideration related to intellectual property rights does not fall within this definition.

Such deliberate/fraudulent misrepresentation refers to any substitution, adulteration, reproduction of an authorized medical product or the manufacture of a medical product that is not an authorized product.

"Identity" shall refer to the name, labelling or packaging or to documents that support the authenticity of an authorized medical product.

"Composition" shall refer to any ingredient or component of the medical product in accordance with applicable specifications authorized/recognized by NRRA.

"Source" shall refer to the identification, including name and address, of the marketing authorization holder, manufacturer, importer, exporter, distributor or retailer, as applicable.

Medical products should not be considered as falsified solely on the grounds that they are unauthorized for marketing in any given country.

Intellectual property rights

8. The terms of reference of the Member State mechanism on SSFFC medical products expressly exclude the protection of intellectual property rights from the mandate of the mechanism and, therefore, the same criteria shall be used in the definitions to be used in its deliberations and work. The term "counterfeit" is now usually defined and associated with the protection of intellectual property rights. For reference purposes, the definitions of "trademark counterfeit goods"[1] and pirated copyright goods[2] are included as defined under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS).

[1] "Trademark counterfeit goods: goods, including packaging, bearing without authorization a trademark that is identical to the trademark validly registered in respect of such goods, or which cannot be distinguished in its essential aspects from such a trademark, and which thereby infringes the rights of the owner of the trademark in question under the law of the country of importation".

[2] "Pirated copyright goods: any goods that are copies made without the consent of the right holder or person duly authorized by the right holder in the country of production, and which are made directly or indirectly from an article where the making of that copy would have constituted an infringement of a copyright or a related right under the law of the country of importation."

9. In the context of medical products, the term “falsified” appears to adequately include all the various types of deliberate misrepresentation of a medical product in such a way which enables the specific exclusion of intellectual property rights.

Conclusion and recommendation

10. This document is not intended to be an exhaustive examination of legal texts and definitions, but; rather, it is meant to start the process of simplifying the current terminology in use by the WHO global surveillance and monitoring system and the Member State mechanism from a public health perspective.

11. Based on the deliberation of the working group it is recommended that the Member State mechanism replace the use of “substandard/spurious/falsely-labelled/falsified/counterfeit medical products” with “substandard and falsified medical products”, as the term to be used in its name and in all future documentation on the subject of medical products of this type.

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ANNEX 6

Global strategy and plan of action on public health, innovation and intellectual property: terms of reference of the overall programme review[1]

[EB140/20, Annex 2 − 10 January 2017]

1. As directed in resolution WHA68.18 (2015), the overall programme review, as distinct from the evaluation, will be a more policy-oriented, forward-looking exercise. The expert review panel's conclusions should identify areas of convergence, in line with the 10 principles of the global strategy and plan of action on public health, innovation and intellectual property (contained in the annex to resolution WHA61.21 (2008)). Guided by the report of the comprehensive evaluation and, where appropriate, taking into account other evidence and involving relevant stakeholders, including public sector entities and all categories of non-State actors in line with the WHO Framework of Engagement with Non-State Actors involved in biomedical research and development, the programme review will:

(a) assess the continued relevance of the aim and objectives and the eight elements of the global strategy and plan of action;

(b) consider the evaluation of the implementation of the global strategy and plan of action so far and its key barriers;

(c) review achievements, good practices, success factors, opportunities, gaps, weaknesses, unsuccessful efforts, remaining challenges, and value for money;

(d) invite, over the course of the evaluation, appropriate input and comment from WIPO, WTO, and UNCTAD and other relevant intergovernmental organizations;

(e) recommend a way forward, including details of what elements or actions should be added, enhanced or concluded in the next stage of implementation of the global strategy and plan of action on public health, innovation and intellectual property, until 2022;

(f) submit a final report to the Health Assembly, including the assessment of the global strategy and plan of action and recommendations on the way forward.

[1] See decision EB140(8).

2. The final report of the overall programme review of the global strategy and plan of action on public health, innovation and intellectual property, focusing on its achievements, remaining challenges and recommendations on the way forward, will be presented to the Seventy-first World Health Assembly in 2018 through the Executive Board at its 142nd session.

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ANNEX 7

Non-State actors admitted into, or maintained in, official relations with WHO by virtue of decision EB140(10)

[EB140/42, Annex 2 – 13 January 2017]

Aga Khan Foundation*
Alzheimer's Disease International*
American Society for Reproductive Medicine*
Bill & Melinda Gates Foundation
Corporate Accountability International*
Drugs for Neglected Diseases initiative*
Family Health International*
Global Alliance for Improved Nutrition*
Grand Challenges Canada
Health on the Net Foundation*
HelpAge International*
Human Rights in Mental Health*
International Association for Child and Adolescent Psychiatry, and Allied Professions*
International Association for Suicide Prevention*
International Association for the Scientific Study of Intellectual Disabilities*
International Baby Food Action Network*
International Bureau for Epilepsy*
International Committee for Monitoring Assisted Reproductive Technologies*
International Commission on Occupational Health*
International Confederation of Midwives*
International Council for Commonality in Blood Banking Automation Inc.*
International Ergonomics Association*
International Federation of Biomedical Laboratory Science*
International Federation of Clinical Chemistry and Laboratory Medicine*
International Federation of Gynecology and Obstetrics*
International Federation on Ageing*
International Lactation Consultant Association*
International League Against Epilepsy*
International Network of Women Against Tobacco*
International Occupational Hygiene Association*
International Organization for Standardization*
International Pediatric Association*
International Physicians for the Prevention of Nuclear War*
International Planned Parenthood Federation*

International Psycho-Oncology Society*
International Rescue Committee
International Society for Biomedical Research on Alcoholism*
International Society for Prosthetics and Orthotics*
International Society of Andrology*
International Union of Nutritional Sciences*
International Women's Health Coalition Inc.*
International Union of Psychological Science*
IntraHealth International Inc.*
Iodine Global Network*
Knowledge Ecology International
Lifting The Burden*
Medicines Patent Pool Foundation*
Médecins Sans Frontières International*
Multiple Sclerosis International Federation*
Stichting Health Action International*
The Commonwealth Pharmacists Association*
The Fred Hollows Foundation
The International Society for the Prevention of Child Abuse and Neglect*
The Population Council, Inc. *
World Association of Echinococcosis *
World Association of Societies of Pathology and Laboratory Medicine*
World Confederation for Physical Therapy*
World Federation for Mental Health*
World Federation of Neurology*
World Federation of Neurosurgical Societies*
World Federation of Occupational Therapists*
World Obesity Federation*
World Psychiatric Association*

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* Based on reports of collaboration for the period under review 2014–2016, the Programme, Budget and Administration Committee of the Executive Board recommended the maintenance in official relations of those non-State actors whose names are followed by an asterisk.

ANNEX 8

Financial and administrative implications for the Secretariat of resolutions and decisions adopted by the Executive Board

Resolution EB140.R5 Improving the prevention, diagnosis and management of sepsis	
A.	**Link to the General Programme of Work and the Programme budget**
1.	**Please indicate to which outcome in the Twelfth General Programme of Work, 2014–2019 and to which output in the Programme budget 2016–2017 this resolution will contribute.** Twelfth General Programme of Work, 2014–2019, category 3, outcome: increased access to interventions for improving health of women, newborns, children and adolescents; category 4, outcome: policies, financing and human resources are in place to increase access to people-centred, integrated health services; category 5, outcome: increased capacity of countries to build resilience and adequate preparedness to mount a rapid, predictable and effective response to major epidemics and pandemics. Programme budget 2016–2017, outputs: 3.1.1; 3.1.2; 3.1.4; 3.1.6; 4.2.3; and 5.2.2.
2.	**Please provide a short justification for considering the resolution, if there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017.** Not applicable.
3.	**Please indicate the estimated implementation time frame (in years or months) for any additional deliverables.** 4.5 years
B.	**Budgetary implications for implementation of additional deliverables**
1.	**Current biennium − estimated, additional budgetary requirements, in US$ millions:** None
(i)	**Please indicate the level of available resources to fund the implementation of the resolution in the current biennium, in US$ millions:** – **How much are the resources available to fund the resolution in the current biennium?** US$ 0.40 million (in-kind staff contribution across regional offices and WHO headquarters). – **How much will the financing gap be?** US$ 1.68 million. – **What are the estimated resources, not yet available, if any, which would help to close the financing gap?** Zero.

2. 2018–2019 (if required): estimated budget requirements, in US$ millions:

US$ 4.63 million.

Level	Staff	Activities	Total
Country offices	0.00	1.20	1.20
Regional offices	1.35	0.48	1.83
Headquarters	1.20	0.40	1.60
Total	2.55	2.08	4.63

3. Future bienniums beyond 2018–2019 (if required) − estimated budgetary requirements, in US$ millions:

US$ 4.63 million.

Resolution EB140.R7 Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018

A. Link to the General Programme of Work and the Programme budget

1. Please indicate to which outcome in the Twelfth General Programme of Work, 2014–2019 and to which output in the Programme budget 2016–2017 this resolution will contribute.

Twelfth General Programme of Work 2014–2019, category 2, outcome: increased access to interventions to prevent and manage noncommunicable diseases and their risk factors. Programme budget 2016–2017, output 2.1.1: development and/or implementation of national multisectoral policies and plans to prevent and control noncommunicable diseases accelerated.

2. Please provide a short justification for considering the resolution, if there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017.

Not applicable.

3. Please indicate the estimated implementation time frame (in years or months) for any additional deliverables.

It is proposed to implement the resolution within the duration of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020.

B. Budgetary implications for implementation of additional deliverables

1. Current biennium − estimated, additional budgetary requirements, in US$ millions:

No additional costs to be accommodated within the approved Programme budget for the current biennium.

(i) Please indicate the level of available resources to fund the implementation of the resolution in the current biennium, in US$ millions:

– How much are the resources available to fund the resolution in the current biennium?

Not applicable.

– How much will the financing gap be?

Not applicable.

– What are the estimated resources, not yet available, if any, which would help to close the financing gap?

Not applicable.

2. 2018–2019 (if required): estimated budget requirements, in US$ millions:

These resource requirements have been taken into account during the proposed Programme budget 2018–2019 for the implementation of the proposed workplan for the global coordination mechanism on the prevention and control of noncommunicable diseases covering the period 2018–2019:

Level	Staff	Activities	Total
Country offices	0	0	0
Regional offices	0	0	0
Headquarters	6.2	3.6	9.8
Total	6.2	3.6	9.8

3. Future bienniums beyond 2018–2019 (if required) − estimated budgetary requirements, in US$ millions:

Not applicable.

Resolution EB140.R8 Confirmation of amendments to the Staff Rules: revised compensation package, related entitlements and salaries for of staff

A. Link to the General Programme of Work and the Programme budget

1. Please indicate to which outcome in the Twelfth General Programme of Work, 2014–2019 and to which output in the Programme budget 2016–2017 this resolution will contribute.

Not applicable.

2. Please provide a short justification for considering the resolution, if there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017.

The amendments described in document EB140/48 stem from the decisions taken by the United Nations General Assembly at its Seventieth session, in resolution 70/244 adopted on 23 December 2015,[1] on the basis of recommendations made by the International Civil Service Commission in its report for the year 2015,[2] and decisions expected to be taken at its Seventy-first session, on the basis of recommendations made by the Commission in its report for the year 2016.[3]

3. Please indicate the estimated implementation time frame (in years or months) for any additional deliverables.

In the light of the time required for system reconfiguration and testing, the resolution is expected to be implemented for the payroll run of May 2017, with a retroactive effective date of 1 January 2017. This applies to **draft resolution 1** (revised compensation package, related entitlements and salaries for staff) and **draft resolution 3** (remuneration of staff in ungraded positions and the Director-General).

With respect to the extension of the mandatory age of separation to 65 for staff members appointed on or before 1 January 2014, taking into account their acquired rights, the related amendments will enter into force:

(a) with effect from 1 January 2018 (in which case **draft resolution 2** is submitted to the Board for its approval); or

(b) on another date, to be specified, beyond January 2018 (in which case **draft resolution 2** would be amended accordingly).

[1] See http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/70/244 (accessed 16 January 2017).

[2] See http://icsc.un.org/resources/pdfs/ar/AR2015.pdf (accessed 16 January 2017).

[3] See http://icsc.un.org/resources/pdfs/ar/AR2016.pdf (accessed 16 January 2017).

B. Budgetary implications for implementation of additional deliverables

1. Current biennium − estimated, additional budgetary requirements, in US$ millions:

It should be noted that payroll costs are always subject to some variability due to post adjustment, exchange rates, mix of staff members in terms of dependents and education grant entitlements among other factors, so these additional costs will be absorbed within the overall payroll budget fluctuations.

(i) Please indicate the level of available resources to fund the implementation of the resolution in the current biennium, in US$ millions:

– How much are the resources available to fund the resolution in the current biennium?

See below.

– How much will the financing gap be?

See below.

– What are the estimated resources, not yet available, if any, which would help to close the financing gap?

Revised compensation package for staff members in the professional and higher categories and related entitlements[1]

In its report for 2015, the Commission estimated the total annual cost savings for all organizations across the United Nations common system to be US$ 113.2 million (a 2–3% reduction in staff costs). However, United Nations General Assembly resolution 70/244 provides for increases in entitlements not presented in the Commission's 2015 report, notably a single parent allowance of 6% of net remuneration. Consequently, the Commission's projections will need to be adjusted in due course. Furthermore, the figures provided in the Commission's report are subject to changes in staff numbers.

It should be noted that immediate savings will not be realized because of implementation costs in the form of enhancements to enterprise resource planning systems (amounting to approximately US$ 2 million for WHO) and transitional costs associated with staff entitlements. Accordingly, the cost savings arising from the changes to the periodicity of within-grade step increases and the reduction in education grant costs related to fewer admissible expenses and limited boarding and travel allowances, will be realized only in the long term. Although WHO expects to see benefits in terms of greater efficiency and simplicity in the administration of entitlements, the transitional measures (applicable for up to five years in some cases) put in place to avoid adversely affecting staff at the time of the changes will bring administrative complexity in the payroll system for several years.

Amendments in relation to the extension of the mandatory age of separation to 65 for staff members appointed on or before 1 January 2014[2]

The extension of the mandatory age of retirement to 65 for serving staff will also have budgetary implications in terms of delaying a more cost-effective realignment of the WHO staffing structure. For the biennium 2018–2019, under the current mandatory age of separation, 182 staff members would have been due to retire in 2018 and 187 in 2019, accounting for 5.9% of the total number of staff members. Of these, 51% in 2018 and 42% in 2019 belong to the professional and higher categories.

The annual succession planning exercises show that in 2014, 2015 and 2016, 12.8% of the posts encumbered by retiring staff were planned for abolition. With the possibility that current staff may stay until the age of 65, the Organization will either keep the staff members on positions that otherwise would have been abolished had they retired, or, if the positions are nonetheless abolished, pay them the expensive entitlements (such as reassignment period, notice period and termination indemnity) to which they would have not been entitled had they retired at the age of 60 or 62.

[1] See document EB140/48, paragraphs 32 and 33.

[2] See document EB140/48, paragraphs 51 and 53–56.

The overall impact of these changes is estimated to be US$ 9–10 million additional costs to the Organization, based on:

(i) the higher salary grade/step for staff members who would have retired compared with the younger staff members who would be appointed to replace them; and

(ii) an estimate of the additional statutory separation costs for staff members who choose to stay on, but whose posts are subsequently abolished, with the largest group being staff members working for the Global Polio Eradication Initiative (US$ 3–4 million of the US$ 9–10 million additional costs). It is likely, however, that some other programmes will also be affected, given the overall budgetary outlook.

There will also be implications in respect of the rejuvenation of the workforce. Many of the positions currently occupied by staff due to retire in 2018 and the following years could be downgraded and would thereby create additional, more cost-effective, opportunities for recruitment at more junior levels.

In its report for the year 2014,[1] the Commission, in making its recommendation to the United Nations General Assembly, noted that increasing the mandatory age of separation to 65 for serving staff will have the positive effect of containing after-service health insurance liabilities; in other words, keeping staff active for longer would not entail a liability for after-service health insurance. As far as WHO is concerned, the impacts on the Organization's long-term estimated liability, and financing, for after-service health insurance are difficult to estimate. On the one hand, there is a positive impact since staff working an extra three or five years will provide additional contributions to the scheme (two thirds of which are a cost to WHO, one third of which is paid by staff). On the other hand, some staff who joined WHO late in their career (for example, at the age of 53, 54 or 55) and who would not have reached the 10-year minimum service period for eligibility to the scheme, will now become eligible, with a resulting negative financial impact. The actual impacts will depend on which staff members choose to extend their age of retirement to 65, and their prior service period in the Organization. The situation will be assessed by independent actuaries, who will make assumptions on these and other variables that have an impact on after-service health insurance.

A similar situation may exist for the pension fund liability and revenue stream, with additional pension payouts as a result of longer service offsetting additional income arising from the pension contributions payable for an additional three years, again funded one third by staff, and two thirds by WHO.

2. 2018–2019 (if required): estimated budget requirements, in US$ millions:

See response to 1(i).

3. Future bienniums beyond 2018–2019 (if required) − estimated budgetary requirements, in US$ millions:

See response to 1(i).

[1] See http://icsc.un.org/resources/pdfs/ar/AR2014.pdf (accessed 16 January 2017).

Decision EB140(3) Human resources for health and implementation of the outcomes of the United Nations' High-Level Commission on Health Employment and Economic Growth

A. Link to the General Programme of Work and the Programme budget

1. Please indicate to which outcome in the Twelfth General Programme of Work, 2014–2019 and to which output in the Programme budget 2016–2017 this decision will contribute.

Twelfth General Programme of Work (2014–2019):
Outcome: Increased access to health services or reduction of risk factors.

Programme budget 2016–2017:
Category: 4. Health systems.

Programme area: Integrated people-centred health services
Outcome: 4.2 – Policies, financing and human resources in place to increase access to integrated, people-centred health services

Output: 4.2.2 – Health workforce strategies oriented towards universal health coverage implemented in countries.

2. Please provide a short justification for considering the decision, if there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017.

The decision reinforces and supports the implementation of the Global Strategy on Human Resources for Health: Workforce 2030 adopted by the World Health Assembly in resolution WHA69.19 (2016), and requests finalization of a five-year action plan that specifies activities for its first phase of implementation.

3. Please indicate the estimated implementation time frame (in years or months) for any additional deliverables.

The decision will generate momentum for the first five-year implementation phase of the 15-year Global Strategy on Human Resources for Health and the broader Sustainable Development Goal horizon to 2030. The decision requests intersessional work between the 140th session of the Executive Board and the Seventieth World Health Assembly to finalize the five-year action plan, which will take two months.

B. Budgetary implications for implementation of additional deliverables

1. Current biennium − estimated, additional budgetary requirements, in US$ millions:

No additional budgetary requirements.

(i) Please indicate the level of available resources to fund the implementation of the decision in the current biennium, in US$ millions:

– How much are the resources available to fund the decision in the current biennium?

Resources are available to fund the decision.

– How much will the financing gap be?

No financing gap.

– What are the estimated resources, not yet available, if any, which would help to close the financing gap?

Not applicable.

2. 2018–2019 (if required): estimated budget requirements, in US$ millions:

Not applicable.

3. Future bienniums beyond 2018–2019 (if required) − estimated budgetary requirements, in US$ millions:

Not applicable.

Decision EB140(4) Poliomyelitis

A. Link to the General Programme of Work and the Programme budget

1. Please indicate to which outcome in the Twelfth General Programme of Work, 2014–2019 and to which output in the Programme budget 2016–2017 this decision will contribute.

Twelfth General Programme of Work, 2014–2019, category 5, outcome: no cases of paralysis due to wild or type-2 vaccine-related poliovirus globally. Programme budget 2016–2017, output 5.5.4: polio legacy work plan finalized and under implementation globally.

2. Please provide a short justification for considering the decision, if there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017.

Not applicable.

3. Please indicate the estimated implementation time frame (in years or months) for any additional deliverables.

A 3–6 month independent study of programmatic, financial and human resource consequences of the end of the polio programme, including cessation of funding, is to be completed mid-2017. The contract is to be issued in February 2017. The results are to be fully reported in January 2018, at the 142nd session of the Executive Board; progress reports are to be given at the Seventieth World Health Assembly, in May 2017, and the Executive Board at its 141st session, following the Health Assembly.

B. Budgetary implications for implementation of additional deliverables

1. Current biennium − estimated, additional budgetary requirements, in US$ millions:

The decision will be supported within the existing Programme budget.

(i) Please indicate the level of available resources to fund the implementation of the decision in the current biennium, in US$ millions:

– How much are the resources available to fund the decision in the current biennium?

None identified at present. US$0.6 million is needed for contracted independent study, including a consultant for 3–6 months to manage/oversee the study and travel to selected countries.

– How much will the financing gap be?

US$ 0.6 million.

– What are the estimated resources, not yet available, if any, which would help to close the financing gap?

As the study will be interprogrammatic, it should be supported from a central source or a donation specified for this purpose.

2. 2018–2019 (if required): estimated budget requirements, in US$ millions:

The potential cost of further development and implementation of transition plans by the Secretariat and countries is to be determined.

3. Future bienniums beyond 2018–2019 (if required) − estimated budgetary requirements, in US$ millions:

Transition is due to be completed by 2020. Essential functions necessary to maintain a polio-free world will need to be sustained after certification of eradication. These include surveillance and laboratory function, ability to respond to any re-emergence and outbreak, continued routine immunization, and containment of poliovirus in laboratories and vaccine manufacturing plants. The costs of these essential functions will be estimated at the end of 2017.

Decision EB140(5) Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits	
A.	**Link to the General Programme of Work and the Programme budget**
1.	**Please indicate to which outcome in the Twelfth General Programme of Work, 2014–2019 and to which output in the Programme budget 2016–2017 this decision will contribute.** The Pandemic Influenza Preparedness (PIP) Framework contributes to outcomes E1 and E2 of the WHO Health Emergencies Programme.
2.	**Please provide a short justification for considering the decision, if there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017.** Extending the application of decision EB131(2) (2012) will allow continued implementation of the PIP Framework Partnership Contribution in 2017.
3.	**Please indicate the estimated implementation time frame (in years or months) for any additional deliverables.** 12 months, January to December 2017.
B.	**Budgetary implications for implementation of additional deliverables** There are no budgetary implications from the decision.
1.	**Current biennium − estimated, additional budgetary requirements, in US$ millions:** No additional budgetary requirement.
(i)	**Please indicate the level of available resources to fund the implementation of the decision in the current biennium, in US$ millions:** Not applicable. **– How much are the resources available to fund the decision in the current biennium?** Not applicable. **– How much will the financing gap be?** Not applicable. **– What are the estimated resources, not yet available, if any, which would help to close the financing gap?** Not applicable.
2.	**2018–2019 (if required): estimated budget requirements, in US$ millions:** Not applicable.
3.	**Future bienniums beyond 2018–2019 (if required) − estimated budgetary requirements, in US$ millions:** Not applicable.

Decision EB140(7) Draft global action plan on the public health response to dementia	
A.	**Link to the General Programme of Work and the Programme budget**
1.	**Please indicate to which outcome in the Twelfth General Programme of Work, 2014–2019 and to which output in the Programme budget 2016–2017 this decision will contribute.** Twelfth General Programme of Work, 2014–2019, category 2, outcome: increased access to services for mental health and substance use disorders. Programme budget 2016–2017, outputs 2.2.1 (countries' capacity strengthened to develop and implement national policies, plans and information systems in line with the comprehensive mental health action plan 2013–2020) and 2.2.2 (countries with technical capacity to develop integrated mental health services across the continuum of promotion, prevention, treatment and recovery).

2. Please provide a short justification for considering the decision, if there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017.

The draft Proposed programme budget 2018–2019 includes a regional office deliverable on providing guidance and support to countries in the region to develop and implement national policies/plans/strategies for dementia; and a headquarters deliverable on establishing a global dementia observatory and assisting Member States in developing and implementing dementia strategies.

3. Please indicate the estimated implementation time frame (in years or months) for any additional deliverables.

Eight years for the duration of the draft global action plan on the public health response to dementia.

B. Budgetary implications for implementation of additional deliverables

1. Current biennium − estimated, additional budgetary requirements, in US$ millions:

Covering July to December 2017:

Total US$ 1.33 million (staff US$ 0.70 million, activities US$ 0.63 million).

At headquarters: one person (100%) at grade P2, one person (75% of one full-time equivalent) at grade P4, one person (25% of one full-time equivalent) at P5, with international expertise in public health and dementia, and one person providing administrative support (50% of one full-time equivalent) at grade G5.

At regional level: an international expert in public health and dementia with knowledge of the needs in their region (50% of one full-time equivalent) at grade P4 in each region.

(i) Please indicate the level of available resources to fund the implementation of the decision in the current biennium, in US$ millions:

– How much are the resources available to fund the decision in the current biennium?

US$ 0.11 million.

– How much will the financing gap be?

US$ 1.22 million.

– What are the estimated resources, not yet available, if any, which would help to close the financing gap?

US$ 0.08 million (a grant expected from the European Commission).

2. 2018–2019 (if required): estimated budget requirements, in US$ millions:

US$ 5.30 million (staff US$ 2.80 million, activities US$ 2.50 million).

3. Future bienniums beyond 2018–2019 (if required) − estimated budgetary requirements, in US$ millions:

Biennium 2020–2021: US$ 5.30 million (staff US$ 2.80 million, activities US$ 2.50 million).

Biennium 2022–2023: US$ 5.30 million (staff US$ 2.80 million, activities US$ 2.50 million).

Biennium 2024–2025: US$ 5.30 million (staff US$ 2.80 million, activities US$ 2.50 million).

Total: US$ 15.90 million (staff US$ 8.40 million, activities US$ 7.50 million) for the three bienniums.

Decision EB140(8) Overall programme review of the global strategy and plan of action on public health, innovation and intellectual property

A. Link to the General Programme of Work and the Programme budget

1. Please indicate to which outcome in the Twelfth General Programme of Work, 2014–2019 and to which output in the Programme budget 2016–2017 this decision will contribute.

Twelfth General Programme of Work, 2014–2019, category 4, outcome: improved access to, and rational use of, safe, efficacious and quality medicines and health technologies. Programme budget 2016–2017, output 4.3.2: implementation of the global strategy and plan of action on public health, innovation and intellectual property.

2.	**Please provide a short justification for considering the decision, if there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017.** Not applicable.
3.	**Please indicate the estimated implementation time frame (in years or months) for any additional deliverables.** January 2017 to October 2017.
B.	**Budgetary implications for implementation of additional deliverables**
1.	**Current biennium − estimated, additional budgetary requirements, in US$ millions:** Zero.
(i)	**Please indicate the level of available resources to fund the implementation of the decision in the current biennium, in US$ millions:** **– How much are the resources available to fund the decision in the current biennium?** US$ 1.01 million. **– How much will the financing gap be?** Zero. **– What are the estimated resources, not yet available, if any, which would help to close the financing gap?** Not applicable.
2.	**2018–2019 (if required): estimated budget requirements, in US$ millions:** Not applicable.
3.	**Future bienniums beyond 2018–2019 (if required) − estimated budgetary requirements, in US$ millions:** Not applicable.

Decision EB140(9) Promoting the health of refugees and migrants	
A.	**Link to the General Programme of Work and the Programme budget**
1.	**Please indicate to which outcome in the Twelfth General Programme of Work, 2014–2019 and to which output in the Programme budget 2016–2017 this decision will contribute.** Currently there is no specific outcome or output on migration in the Twelfth General Programme of Work, 2014–2019 or the Programme budget 2016–2017. However, the Organization has linked its current activities on health and migration to outputs 4.2.1 (equitable integrated, people-centred service delivery systems in place in countries and public-health approaches strengthened) and 4.2.3 (countries enabled to improve patient safety and quality of services, and patient empowerment within the context of universal health coverage) in the Programme budget 2016–2017.
2.	**Please provide a short justification for considering the decision, if there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017.** Health policy approaches as outlined in resolution WHA61.17 (2008) have not kept pace with the growing challenges of unprecedented migration flows and do not sufficiently deal with the existing health inequalities, gaps in social protection, and access to health services, goods and facilities of refugees and migrants. These challenges have become a crisis that poses multiple political, foreign policy, financial, security and health implications. Numerous national and international organizations and civil society are finding ways to improve aspects of refugees' and migrants' health and their access to health services. The approaches are often fragmented and costly, operate in parallel to national health systems and depend on external funding and lack sustainability. There is lack of a coherent comprehensive global strategy to tackle migrant health. In addition, governments face the challenge of incorporating the health needs of refugees and migrants in national plans, policies and strategies. There

is a need to bridge short-term humanitarian health assistance with long-term health system strengthening and to integrate refugees and migrants within national health care systems. This is essential for achieving the Sustainable Development Goals, to ensure the right to health for all and to leave no one behind.

In addition, new global frameworks, such as the Sustainable Development Goals of the 2030 Agenda for Sustainable Development and the New York Declaration for Refugees and Migrants (adopted by the United Nations General Assembly in resolution 71/1 (2016)), and other new relevant Health Assembly resolutions have to be taken into account in tackling the health needs of refugees and migrants. These were not reflected in resolution WHA61.17 (2008) on the health of migrants. There is therefore a need to update resolution WHA61.17 (2008).

3. Please indicate the estimated implementation time frame (in years or months) for any additional deliverables.

2.5 years.

B. Budgetary implications for implementation of additional deliverables

1. Current biennium − estimated, additional budgetary requirements, in US$ millions:

None.

(i) Please indicate the level of available resources to fund the implementation of the decision in the current biennium, in US$ millions:

– How much are the resources available to fund the decision in the current biennium?

Zero.

– How much will the financing gap be?

US$ 0.93 million.

– What are the estimated resources, not yet available, if any, which would help to close the financing gap?

Zero.

2. 2018–2019 (if required): estimated budget requirements, in US$ millions:

US$ 2.78 million.

Level	Staff	Activities	Total
Country offices	0.00	0.50	0.50
Regional offices	0.00	0.40	0.40
Headquarters	1.46	0.42	1.88
Total	1.46	1.32	2.78

3. Future bienniums beyond 2018–2019 (if required) − estimated budgetary requirements, in US$ millions:

Not applicable – budgetary requirements will be estimated when a framework and action plan is developed in 2018.