



WORLD HEALTH ORGANIZATION

SEVENTY-SECOND WORLD HEALTH ASSEMBLY

GENEVA, 20–28 MAY 2019

**RESOLUTIONS AND DECISIONS
ANNEXES**

GENEVA
2019

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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

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

PREFACE

The Seventy-second World Health Assembly was held at the Palais des Nations, Geneva, from 20 to 28 May 2019, in accordance with the decision of the Executive Board at its 143rd session.¹

¹ Decision EB143(5) (2018).

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¹ Adopted at the second plenary meeting.

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¹ See page ix.

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¹ See Annex 7.

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A72/DIV./3	List of decisions and resolutions
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OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES¹

President

Dr Bounkong SYHAVONG
(Lao People's Democratic Republic)

Vice-Presidents

H.E. Ms Socorro Flores LIERA (Mexico)
Mr Abdoulaye Diouf SARR (Senegal)
Dr Hussein Abdul Rahman AL RAND
(United Arab Emirates)
Dr Alisher SHADMANOV (Uzbekistan)
Mrs Dechen WANGMO (Bhutan)

Secretary

Dr Tedros Adhanom GHEBREYESUS,
Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Bahrain, Cambodia, Dominican Republic, Eritrea, Indonesia, Liberia, Marshall Islands, Montenegro, Poland, Seychelles, Slovakia and Suriname.

Chairman: Dr Acep SOMANTRI (Indonesia)

Vice-Chairman: Mr Berhane
GHEBRETINSAE (Eritrea)

Secretary: Ms Françoise MOURAIN-
SCHUT, Senior Legal Officer

General Committee

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the chairmen of the main committees, together with the delegates of the following Member States: Bahamas, China, Congo, Cuba, Democratic Republic of the Congo, Djibouti, France, Honduras, Mongolia, Myanmar, Niger, Romania, Russian Federation,

Somalia, South Africa, United Kingdom of Great Britain and Northern Ireland and United States of America.

Chairman: Dr Bounkong SYHAVONG
(Lao People's Democratic Republic)

Secretary: Dr Tedros Adhanom
GHEBREYESUS, Director-General

MAIN COMMITTEES

Under Rule 33 of the Rules of Procedure of the World Health Assembly, each delegation is entitled to be represented on each main committee by one of its members.

Committee A

Chairman: Dr Silvia Paula Valentim
LUTUCUTA (Angola)

Vice-Chairmen: Dr Yasuhiro SUZUKI (Japan)
and Dr Mohammad Assai ARDAKANI
(Islamic Republic of Iran)

Rapporteur: Ms Laura BORDÓN (Paraguay)

Secretary: Mr Ian ROBERTS, Coordinator,
Library and Information Networks for
Knowledge

Committee B

Chairman: Mr Herbert BARNARD
(Netherlands)

Vice-Chairmen: Dr Karen GORDON-
CAMPBELL (Guyana) and Mr Abdulla
AMEEN (Maldives)

Rapporteur: Dr Ahmad Jan NAEEM
(Afghanistan)

Secretary: Dr Clive ONDARI, Coordinator,
Safety and Vigilance

REPRESENTATIVES OF THE EXECUTIVE BOARD

Mrs Maria Nazareth Farani AZEVÊDO (Brazil)

Dr Päivi SILLANAUKKEE (Finland)

Dr Simon Mfanzile ZWANE (Eswatini)

Ms Glenys BEAUCHAMP (Australia)

¹ In addition, the list of delegates and other participants is contained in document A72/DIV./1 Rev.1.

RESOLUTIONS AND DECISIONS

RESOLUTIONS

WHA72.1 Programme budget 2020–2021

The Seventy-second World Health Assembly,

Having considered the Proposed programme budget 2020–2021;¹

Having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-second World Health Assembly;²

Noting that the Proposed programme budget 2020–2021 is the first programme budget to be prepared in line with the Thirteenth General Programme of Work, 2019–2023 and WHO's triple billion strategic priority approach;

Stressing the importance of strengthening the normative functions of the Organization, while also welcoming the focus on impact, capacity and integrated systems at the country level;

Recalling that the allocation of financial resources must be accompanied by progress monitoring and an expectation of measurable results;

Welcoming the incorporation of emergency operations and appeals as a costed element in the Proposed programme budget 2020–2021;

Further welcoming the work being conducted to identify opportunities for efficiency savings across the entire Organization, while reaffirming the need for enabling functions to be adequately financed across all levels;

Affirming WHO's leadership of a transformative agenda that supports countries in their efforts to reach all health-related Sustainable Development Goal targets;

Recognizing WHO's full commitment to, and engagement in, the implementation of United Nations development system reform;

Recognizing that the Proposed programme budget 2020–2021 presents a new results framework with a balanced scorecard that will assess the outputs of the Secretariat across the three levels of the Organization in six dimensions – leadership; global goods; country support; gender equality, equity and rights; value for money; and leading indicators – and that the new WHO Impact Framework will assess the results of the Thirteenth General Programme of Work, 2019–2023 in its entirety, and its impact on global health;

Stressing that proposed increases above the level of the Proposed programme budget 2020–2021 should be requested only when necessary for the purpose of the Organization's mandated activities and

¹ Document A72/4.

² Document A72/63.

after all possible steps have been taken to finance such increases through efficiency savings and prioritization,

1. APPROVES the programme of work, as outlined in the Proposed programme budget 2020–2021, and its strategic priorities and other areas, noting also the background information on its operationalization;
2. APPROVES the budget for the financial period 2020–2021, under all sources of funds, namely, assessed and voluntary contributions, of US\$ 5840.4 million;
3. ALLOCATES the budget for the financial period 2020–2021 to the following strategic priorities and other areas:

Strategic priorities

1. One billion more people benefiting from universal health coverage, US\$ 1358.8 million;
2. One billion more people better protected from health emergencies, US\$ 888.8 million;
3. One billion more people enjoying better health and well-being, US\$ 431.1 million;
4. More effective and efficient WHO providing better support to countries, US\$ 1090.0 million (including financing the United Nations Resident Coordinator system in accordance with relevant resolutions of the United Nations General Assembly);

Other areas

- Polio eradication (US\$ 863.0 million), special programmes (US\$ 208.7 million) totalling US\$ 1071.7 million;
- Emergency operations and appeals (US\$ 1000.0 million) for which the budget requirement, given the event-driven nature of the activities concerned, is an estimated figure informed by recent experience that can be subject to increase as necessary;

4. RESOLVES that the budget will be financed as follows:
 - by net assessments on Member States adjusted for estimated Member State non-assessed income, for a total of US\$ 956.9 million;
 - from voluntary contributions, for a total of US\$ 4883.5 million;
5. FURTHER RESOLVES that the gross amount of the assessed contribution for each Member State shall be reduced by the sum standing to their credit in the Tax Equalization Fund; that this reduction shall be adjusted in the case of those Members that require staff members to pay income taxes on their WHO emoluments, taxes which the Organization reimburses to the said staff members; and that the amount of such tax reimbursements is estimated at US\$ 21.0 million, resulting in a total assessment on Members of US\$ 977.9 million;
6. DECIDES that the Working Capital Fund shall be maintained at its existing level of US\$ 31.0 million;

7. AUTHORIZES the Director-General to use the assessed contributions together with the voluntary contributions, subject to the availability of resources, to finance the budget as allocated in paragraph 3, up to the amounts approved;
8. FURTHER AUTHORIZES the Director-General, where necessary, to make budget transfers among the four strategic priorities, up to an amount not exceeding 5% of the amount allocated to the strategic priority from which the transfer is made. Any such transfers will be reported with an explanation in the statutory reports to the respective governing bodies;
9. FURTHER AUTHORIZES the Director-General, where necessary, to incur additional expenditures in the emergency operations and appeals area, subject to availability of resources;
10. FURTHER AUTHORIZES the Director-General, where necessary, to incur additional expenditures in the special programmes component of the budget beyond the amount allocated for this component, as a result of additional governance and resource mobilization mechanisms, as well as their budget cycle, which inform the annual and/or biennial budgets for these special programmes, subject to availability of resources;
11. REQUESTS the Director-General:
- (1) to continue developing the results framework in consultation with Member States, including through the regional committees, and to present it to the Executive Board at its 146th session;
 - (2) to present a resource mobilization strategy to the Executive Board at its 146th session;
 - (3) to submit regular reports to Member States on the state of financing and implementation of the Programme budget, including a mid-term results report to the Health Assembly, through the Executive Board and its Programme, Budget and Administration Committee;
 - (4) to submit to the Seventy-fifth World Health Assembly in 2022, a report on: the implementation of the entire Programme budget over the period 2020–2021; and outputs by major offices and at the country level, including as measured by balanced scorecards, and, as appropriate, by outcome indicators;
 - (5) to control costs and secure efficiencies across the entire Organization, and to report to the Health Assembly with detailed information on savings and efficiencies, through the Executive Board and its Programme, Budget and Administration Committee.

(Sixth plenary meeting, 24 May 2019.–
Committee A, first report)

WHA72.2 Primary health care¹

The Seventy-second World Health Assembly,

Having considered the report on universal health coverage: primary health care towards universal health coverage;²

¹ See Annex 9 for the financial and administrative implications for the Secretariat of this resolution.

² Document A72/12.

Recalling the 2030 Agenda for Sustainable Development, adopted in 2015, in particular Sustainable Development Goal 3, which calls on stakeholders to ensure healthy lives and promote well-being for all individuals at all ages;

Reaffirming the ambitious and visionary Declaration of Alma-Ata (1978) in pursuit of health for all;

Welcoming the convening of the Global Conference on Primary Health Care: from Alma-Ata towards universal health coverage and the Sustainable Development Goals (Astana, Kazakhstan, 25 and 26 October 2018), during which Member States renewed their commitment to primary health care through a whole-of-society approach around primary health care as a cornerstone of a sustainable health system for universal health coverage and the health-related Sustainable Development Goals, in particular target 3.8 on achieving universal health coverage;

Recalling the approach regarding primary health care and universal health coverage contained in resolution WHA69.11 (2016) on health in the 2030 Agenda for Sustainable Development,

1. WELCOMES the Declaration of Astana adopted at the Global Conference on Primary Health Care in Astana on 25 October 2018;¹
2. URGES Member States² to take measures to share and implement the vision and commitments of the Declaration of Astana according to national contexts;
3. CALLS UPON all relevant stakeholders:
 - (1) to align their actions and support to national policies, strategies and plans, in the spirit of partnership and effective development cooperation, in implementing the vision and commitments of the Declaration of Astana;
 - (2) to provide support to Member States in mobilizing human, technological, financial and information resources to help to build strong and sustainable primary health care, as envisaged in the Declaration of Astana;
4. REQUESTS the Director-General:
 - (1) to support Member States, as appropriate, in strengthening primary health care, including the implementation of the vision and commitments of the Declaration of Astana in coordination with all relevant stakeholders;
 - (2) to develop, in consultation with, and with the involvement of more expertise from, Member States, and in time for consideration by the Seventy-third World Health Assembly, an operational framework for primary health care, to be taken fully into account in the WHO general programmes of work and programme budgets in order to strengthen health systems and support countries in scaling-up national implementation efforts on primary health care;
 - (3) to ensure that WHO promotes the vision and commitments in the Declaration of Astana in its work and overall organizational efforts, and enhances institutional capacity and leadership across WHO at all levels of the Organization, including regional and country offices, in order to support Member States in strengthening primary health care;

¹ See Annex 1.

² And, where applicable, regional economic integration organizations.

(4) to report regularly through the Executive Board to the Health Assembly on progress made in strengthening primary health care, including implementation of the vision and commitments of the Declaration of Astana, as part of all reporting on progress towards achieving universal health coverage by 2030.

(Sixth plenary meeting, 24 May 2019 –
Committee A, second report)

WHA72.3 Community health workers delivering primary health care: opportunities and challenges¹

The Seventy-second World Health Assembly,

Having considered the report on community health workers delivering primary health care: opportunities and challenges,² and the associated WHO guideline on health policy and system support to optimize community health worker programmes;³

Inspired by the ambition of the 2030 Agenda for Sustainable Development, with its pledge to leave no one behind, its 17 integrated and indivisible goals and its 169 targets;

Recognizing that universal health coverage is central to achievement of the Sustainable Development Goals, and that a strong primary health care sector is one of the cornerstones of a sustainable health system;

Emphasizing that health workers are integral to building strong, resilient and safe health systems that contribute to the achievement of the Sustainable Development Goals and targets related to nutrition, education, health, gender, employment and the reduction of inequalities;

Noting in particular that Sustainable Development Goal 3 (Ensure healthy lives and promote well being for all at all ages) and its targets will be advanced through substantive and strategic investments in the global health workforce, as well as a substantial shift in health workforce-related planning, education, deployment, retention, management and remuneration, supported by strong systems that enable and empower the health workforce to deliver safe and high-quality care for all;

Recognizing the need for more coherent and inclusive approaches to safeguard and expand primary health care as a pillar of universal health coverage in emergencies, ensuring the continuum and provision of essential health services and public health functions, in line with humanitarian principles;

Concerned by the threats against humanitarian personnel and health workers, hospitals and ambulances, which severely restrict the provision of life-saving assistance and hinder the protection of populations at risk;

Expressing deep concern at the significant security risks faced by humanitarian and health personnel, United Nations and associated personnel, as they operate in increasingly high-risk environments;

¹ See Annex 9 for the financial and administrative implications for the Secretariat of this resolution.

² Document A72/13.

³ WHO guideline on health policy and system support to optimize community health worker programmes. Geneva: World Health Organization; 2018 (available at <https://www.who.int/hrh/community/en/>, accessed 28 May 2019).

Noting further the importance of health workers to the realization of the three interconnected strategic priorities in WHO's Thirteenth General Programme of Work, 2019–2023, namely: achieving universal health coverage, addressing health emergencies and promoting healthier populations;

Reaffirming resolution WHA69.19 (2016) on the global strategy on human resources for health: workforce 2030, in which the Health Assembly adopted the Global Strategy on Human Resources for Health: Workforce 2030, with the Global Strategy identifying the opportunity, inter alia, to optimize the performance, quality and impact of community health workers for the achievement of universal health coverage and the Sustainable Development Goals;

Reaffirming also resolution WHA70.6 (2017) on human resources for health and implementation of the outcomes of the United Nations' High-Level Commission on Health Employment and Economic Growth, including its call for collaboration to "stimulate investments in creating decent health and social jobs with the right skills, in the right numbers and in the right places, particularly in countries facing the greatest challenges in attaining universal health coverage" and "to strengthen the progressive development and implementation of national health workforce accounts";

Recalling the Declaration of Alma-Ata (1978) and the Declaration of Astana from the Global Conference on Primary Health Care: from Alma-Ata towards universal health coverage and the Sustainable Development Goals (Astana, Kazakhstan, 25 and 26 October 2018) through which participating governments reaffirmed their commitments to people-centred health care services, recognized human resources for health as a key component of successful primary health care, and committed themselves to "create decent work and appropriate compensation for health professionals and other health personnel working at the primary health care level to respond effectively to people's health needs in a multidisciplinary context";

Emphasizing further that investment in universal health coverage, including investment in the education, employment and retention of the health workforce, is a major driver of economic growth;

Acknowledging that gaps in human resources and community health workforces within health systems have to be addressed, notably through a multisectoral and community-centred approach, in order to assure that universal health coverage and comprehensive health services reach difficult to access areas and vulnerable populations;

Recognizing that globally seven out of every 10 jobs in the health and social sectors are held by women and that accelerating investments in job creation and decent work in primary health care will have a positive impact on women and young people, thereby supporting achievement of Sustainable Development Goal 5 (Achieve gender equality and empower all women and girls) and Goal 8 (Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all);

Noting the launch in 2018 of the World Bank Group's Human Capital Project, which calls for more and better investment in the education, health and skills of people and thus accelerates progress towards the Sustainable Development Goals, and its potential to leverage new investments in the health workers who provide primary health care services;

Recognizing the published evidence and WHO's existing guidelines, as consolidated in the WHO guideline on health policy and system support to optimize community health worker programmes, on the role, effectiveness and cost-effectiveness of community health workers;

Highlighting the role of community health workers in advancing equitable access to safe, comprehensive health services in urban and rural areas and the reduction of inequities, including with

respect to residence, gender, education and socioeconomic position, as well as their role in gaining the trust and engagement of the communities served;

Noting with concern the uneven integration of community health workers into health systems, as well the limited use of evidence-informed policies, international labour standards and best practices to inform the education, deployment, retention, management and remuneration of community health workers, and noting the negative impact this may have on access to and quality of health services and patient safety;

Reaffirming the WHO Global Code of Practice on the International Recruitment of Health Personnel, which calls upon Member States to provide equal rights, terms of employment, and conditions of work for domestic and migrant health workers;

Noting that community health workers are an integral part of all phases of an emergency health response (prevention, detection and response) in their own communities and are indispensable for contributing to ongoing primary health care services during emergencies,

1. TAKES NOTE of the WHO guideline on health policy and system support to optimize community health worker programmes;¹

2. URGES all Member States,² as appropriate to local and national contexts and with the objective of the success of primary health care and the achievement of universal health coverage:

(1) to align the design, implementation, performance and evaluation of community health worker programmes, by means including the greater use of digital technology, with the consolidated evidence presented in the WHO guideline on health policy and system support to optimize community health worker programmes, with specific emphasis on implementing these programmes in order to enable community health workers to deliver safe and high-quality care;

(2) to adapt as appropriate and support implementation of the WHO guideline on health policy and system support to optimize community health worker programmes at national level as part of national health workforce and broader health sector employment and economic development strategies, in line with national priorities, resources, and specificities;

(3) to strengthen the relevance, effectiveness and implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel, including cooperation with health ministries, civil service commissions, and employers to deliver fair terms for health workers and a positive practice environment to enable their effective deployment, retention and adequate motivation to deliver high-quality care and build a positive relationship with patients;

(4) to allocate, as part of broader health workforce strategies and financing, adequate resources from domestic budgets and from a variety of sources, as appropriate, to the capital and recurrent costs required for the successful implementation of community health worker programmes and for the integration of community health workers into the health workforce in the context of investments in primary health care, health systems and job creation strategies, as appropriate;

(5) to improve and maintain the quality of health services provided by community health workers in line with the consolidated evidence presented in the WHO guideline on health policy

¹ WHO guideline on health policy and system support to optimize community health worker programmes. Geneva: World Health Organization; 2018 (<http://apps.who.int/iris/handle/10665/275474>, accessed 20 September 2019).

² And, where applicable, regional economic integration organizations.

and system support to optimize community health worker programmes, including appropriate pre-service selection and training, competency-based certification, and supportive supervision;

(6) to strengthen voluntary collection and sharing of data, based on national legislation, on community health workers and on community health worker programmes, through the use of national health workforce accounts, as appropriate, thus enabling national reporting on Sustainable Development Goal indicator 3.c.1 on the density and distribution of their health workforce;

(7) to ensure the respect and protection of all medical personnel and humanitarian personnel exclusively engaged in medical duties, their means of transport and equipment, as well as hospitals and other medical facilities;

3. INVITES international, regional, national and local partners to support implementation of the WHO guideline on health policy and system support to optimize community health worker programmes, taking into account national context, and to contribute to monitoring and evaluation of implementation;

4. ALSO INVITES global health initiatives, bilateral and multilateral financing agencies and development banks to support national community health worker programmes, in line with the approach of the WHO guideline on health policy and system support to optimize community health worker programmes, with programme development and financing decisions for human capital and health workforce development, as appropriate to national context and national resources;

5. REQUESTS the Director-General:

(1) to continue to collect and evaluate data on community health worker performance and impacts, in order to ensure a strong evidence base for their promotion, especially in the context of low- and middle-income countries;

(2) to integrate and monitor the implementation of the WHO guideline on health policy and system support to optimize community health worker programmes in the Organization's normative and technical cooperation activities in support of universal health coverage, primary health care, health systems, and disease and population health priorities, including patient safety, as relevant to the Thirteenth General Programme of Work, 2019–2023;

(3) to provide support to Member States, upon request, with respect to implementation of the WHO guideline on health policy and system support to optimize community health worker programmes in alignment with national health labour markets and health care priorities;

(4) to support information exchange, technical cooperation between Member States and relevant stakeholders – including South–South cooperation – and implementation research in respect of community health workers, primary health care teams and supportive supervision, including supervision performed by, inter alia, senior community health workers and other health professionals (for example, clinical officers, midwives, nurses, pharmacists and physicians);

(5) to recognize the role of community health workers in an emergency, and support Member States on how to integrate them within an emergency response, as appropriate to local and national context and national resources;

(6) to strengthen WHO's capacity and leadership on human resources for health at all levels of the Organization through engagement with all relevant stakeholders and provision of high-quality and timely technical assistance from global, regional and country levels to accelerate implementation of: resolution WHA69.19 (2016) on the global strategy on human resources for

health; resolution WHA70.6 (2017) on human resources for health and implementation of the outcomes of the United Nations' High-Level Commission on Health Employment and Economic Growth, in which the Health Assembly adopted "Working for Health": the ILO, OECD, WHO five-year action plan for health employment and inclusive economic growth (2017–2021); and future work on community health worker programmes;

(7) to submit a report every three years to the Health Assembly on progress made in implementing this resolution, integrated with the regular progress reporting on implementation of resolution WHA69.19 (2016) on the global strategy on human resources for health: workforce 2030.

(Sixth plenary meeting, 24 May 2019 –
Committee A, second report)

WHA72.4 Preparation for the high-level meeting of the United Nations General Assembly on universal health coverage¹

The Seventy-second World Health Assembly,

Having considered the Director-General's report on preparation for the high-level meeting of the United Nations General Assembly on universal health coverage;²

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

Recalling also United Nations General Assembly resolution 70/1 (2015) entitled "Transforming our world: The 2030 Agenda for Sustainable Development," by which Member States adopted a comprehensive, far-reaching and people-centred set of universal and transformative sustainable development goals and targets that are integrated and indivisible; and recognizing that achieving universal health coverage will greatly contribute to ensuring healthy lives and well-being for all at all ages;

Recognizing that health is a precondition for and an outcome and indicator of all three dimensions – economic, social and environmental – of sustainable development;

Acknowledging that the Sustainable Development Goals are aimed at realizing the human rights of all, leaving no one behind and reaching those farthest behind first by, inter alia, achieving gender equality and empowerment of women and girls;

Recognizing that through the adoption of the 2030 Agenda and its Sustainable Development Goals on 25 September 2015, Heads of State and Government and High Representatives made a bold commitment to achieve universal health coverage by 2030, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all;

Recognizing also that Heads of State and Government and High Representatives committed themselves to ensuring, by 2030, universal access to sexual and reproductive health care services,

¹ See Annex 9 for the financial and administrative implications for the Secretariat of this resolution.

² Document A72/14.

including for family planning, information and education, and the integration of reproductive health into national strategies and programmes;

Recalling resolution WHA69.11 (2016) on health in the 2030 Agenda for Sustainable Development, which recognizes that universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative, rehabilitative and palliative essential health services, and essential, safe, affordable, effective, and quality medicines and vaccines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable, and marginalized segments of the population;

Recalling also United Nations General Assembly resolution 67/81 of 12 December 2012, entitled “Global health and foreign policy,” which urges governments, civil society organizations and international organizations to collaborate and to promote the inclusion of universal health coverage as an important element on the international development agenda, as a means of promoting sustained, inclusive and equitable growth, social cohesion and the well-being of the population, as well as achieving other milestones for social development;

Recognizing the responsibility of governments to urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality health care services, and reaffirming the primary responsibility of Member States to determine and promote their own paths towards achieving universal health coverage;

Recalling United Nations General Assembly resolution 69/313 on the Addis Ababa Action Agenda of the Third International Conference on Financing for Development, adopted on 27 July 2015, which reaffirmed the strong political commitment to address the challenge of financing and creating an enabling environment at all levels for sustainable development in the spirit of global partnership and solidarity, and which encouraged countries to consider setting nationally appropriate spending targets for quality investments in health and better alignment of global health initiatives’ programmes to national systems;

Recalling also United Nations General Assembly resolution 72/139 of 12 December 2017, entitled “Global health and foreign policy: addressing the health of the most vulnerable for an inclusive society”, in which Member States decided to hold a high-level meeting of the General Assembly in 2019 on universal health coverage;

Recalling further the United Nations General Assembly resolution 72/138 of 12 December 2017, entitled “International Universal Health Coverage Day”, in which the General Assembly decided to proclaim 12 December as International Universal Health Coverage Day;

Reaffirming WHO Member States’ commitment in line with resolution WHA71.1 (2018) on the Thirteenth General Programme of Work, 2019–2023 to support the work towards achieving the vision of the “triple billion” goals, including 1 billion more people benefiting from universal health coverage, 1 billion more people better protected from health emergencies, as well as further contributing to 1 billion more people enjoying better health and well-being;

Recalling United Nations General Assembly resolution 73/2 of 10 October 2018 on the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, in which Heads of State and Government and representatives of States and Governments committed, inter alia, to promote increased access to affordable, safe, effective and quality medicines and diagnostics and other technologies, reaffirming the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement), as amended, and also reaffirming the Doha Declaration on the TRIPS Agreement and Public Health (2001), which recognizes

that intellectual property rights should be interpreted and implemented in a manner supportive of the right of Member States to protect public health and, in particular, to promote access to medicines for all, and which notes the need for appropriate incentives in the development of new health products;

Reiterating that health research and development should be needs-driven, evidence-based, guided by the core principles of affordability, effectiveness, efficiency and equity and considered a shared responsibility;

Recalling all previous Health Assembly resolutions aimed at promoting physical and mental health and well-being, as well as contributing to the achievement of universal health coverage;

Noting with great concern that the current slow progress in achieving universal health coverage means that many countries are not on track to achieve target 3.8 of the Sustainable Development Goals on achieving universal health coverage;

Noting also that health is a major driver of economic growth;

Noting further that current government spending on and available resources for health, particularly in many low- and middle-income countries, are not adequate for achieving universal health coverage, including financial risk protection of the population;

Acknowledging the important role and necessary contribution of nongovernmental organizations, private sector entities, philanthropic foundations, and academic institutions, as appropriate, to the achievement of national objectives for universal health coverage, and the need in this regard for synergy and collaboration among all relevant stakeholders;

Recognizing the role of parliamentarians in advancing the universal health coverage agenda;

Noting that investment is essential for strong, transparent, accountable, and effective health service delivery systems, including an adequately distributed, skilled, motivated, and fit-for-purpose health workforce;

Recognizing that effective and financially sustainable implementation of universal health coverage is based on a resilient and responsive health system with capacities for broad public health measures, disease prevention, health protection, health promotion, and addressing determinants of health through policies across sectors, including promotion of the health literacy of the population;

Noting that the increasing number of complex emergencies is hindering the achievement of universal health coverage, and that coherent and inclusive approaches to safeguard universal health coverage in emergencies are essential, including through international cooperation, ensuring the continuum and provision of essential health services and public health functions, in line with humanitarian principles;

Recognizing the fundamental role of primary health care in achieving universal health coverage and targets of the health-related Sustainable Development Goals, as envisioned in the Declaration of Astana endorsed at the Global Conference on Primary Health Care (Astana, Kazakhstan, 25 and 26 October 2018), and in providing equitable access to a comprehensive range of services and care that are people-centred, gender-sensitive, high quality, safe, integrated, accessible, available and affordable, and that contribute to the health and well-being of all;

Recognizing also that patient safety, strengthening health systems, and access to quality promotive, preventive, curative and rehabilitation, services, together with palliative care, are essential to achieving universal health coverage,

1. URGES Member States:¹

(1) to accelerate progress towards achieving Sustainable Development Goal target 3.8 on universal health coverage by 2030, leaving no one behind, especially the poor, the vulnerable and marginalized populations;

(2) to support the preparation for the high-level meeting of the United Nations General Assembly in 2019 on universal health coverage, participating at the highest possible level, preferably at the level of Head of State and Government, and to engage in the development of an action-oriented, consensus-based political declaration;

(3) to continue to mobilize adequate and sustainable resources for universal health coverage, as well as ensuring efficient, equitable and transparent resource allocation through good governance of health systems; and to ensure collaboration across sectors, as appropriate, with a special focus on reducing health inequities and inequalities;

(4) to support better prioritization and decision-making, notably by strengthening institutional capacities and governance on health intervention and technology assessment, in order to achieve efficiencies and take evidence-based decisions, while respecting patient privacy and promoting data security; and to encourage the greater and systematic utilization of new technologies and approaches, including digital technologies and integrated health information systems as a means of promoting equitable, affordable, and universal access to health and to inform policy decisions in support of universal health coverage;

(5) to continue investing in and strengthening primary health care as a cornerstone of a sustainable health system, to achieve universal health coverage and targets of the health-related Sustainable Development Goals, with a view to providing a comprehensive range of services and care that are people-centred, of high quality, safe, integrated, accessible, available and affordable, as well as providing public health functions as envisioned in the Declaration of Astana from the Global Conference on Primary Health Care (Astana, Kazakhstan, 25 and 26 October 2018) and implementing the commitments of that Declaration;

(6) to continue investing in and strengthening gender-sensitive health care services that address gender-related barriers to health and secure women and girls' equitable access to health, in order to realize the right to the enjoyment of the highest attainable standard of health for all and achieve gender equality and the empowerment of women and girls;

(7) to invest in an adequate, competent and committed health workforce and promote the recruitment, development, training, and retention of the health workforce in developing countries, especially in least developed countries and small island developing States, by active implementation of the Global Strategy on Human Resources for Health: Workforce 2030;

(8) to promote access to affordable, safe, effective, and quality medicines, vaccines, diagnostics, and other technologies;

(9) to support research and development on medicines and vaccines for communicable and noncommunicable diseases, including neglected tropical diseases, particularly those that primarily affect developing countries;

¹ And, where applicable, regional economic integration organizations.

(10) to consider integrating, as appropriate, safe and evidence-based traditional and complementary medicine services within national and/or subnational health systems, particularly at the level of primary health care, according to national context and priorities;

(11) to promote more coherent and inclusive approaches to safeguard universal health coverage in emergencies, including through international cooperation, ensuring the continuum and provision of essential health services and public health functions, in line with humanitarian principles;

(12) to promote health literacy in the population, especially among vulnerable groups, in order to strengthen patient involvement in clinical decision-making, with a focus on health professional–patient communication, and to further invest in easily accessible, accurate, understandable, and evidence-based health information, including through the internet;

(13) to continue to strengthen disease prevention and health promotion by addressing the determinants of health and health equity through multisectoral approaches involving the whole of government and the whole of society, as well as the private sector;

(14) to strengthen monitoring and evaluation platforms to support regular tracking of the progress made in improving equitable access to a comprehensive range of services and care within the health system and to financial risk protection and to make best use of such platforms for policy decisions;

(15) to make the best use of the annual International Universal Health Coverage Day, including by considering appropriate activities, in accordance with national needs and priorities;

2. CALLS UPON all development cooperation partners and stakeholders from the health sector and beyond to harmonize, synergize, and enhance their support to countries' objectives in achieving universal health coverage, and encourages the engagement of such partners and stakeholders in, as appropriate, the development of the global action plan for healthy lives and well-being for all in order to accelerate the progress on Sustainable Development Goal 3 (Ensure healthy lives and promote health and well-being for all at all ages) and other health-related Sustainable Development Goals and targets in order to achieve the 2030 Agenda for Sustainable Development;

3. REQUESTS the Director-General:

(1) to fully support Member States' efforts, in collaboration with the broader United Nations system and other relevant stakeholders, towards achieving universal health coverage by 2030, in particular with regard to health systems strengthening, including by strengthening WHO's normative work and the Organization's capacity to provide technical support and policy advice to Member States;

(2) to work closely with the Inter-Parliamentary Union to raise further awareness among parliamentarians about universal health coverage and fully engage them both in pursuing advocacy and in providing sustained political support towards achieving universal health coverage by 2030;

(3) to facilitate and support the learning from, and sharing of, universal health coverage experiences, best practices and challenges across WHO Member States, including by engaging relevant non-State actors, as appropriate, as well as initiatives such as the International Health Partnership for Universal Health Coverage 2030, and in support of the preparatory process and the high-level meeting of the United Nations General Assembly on universal health coverage;

- (4) to produce a report on universal health coverage as a technical input to facilitate informed discussions at the high-level meeting of the United Nations General Assembly on universal health coverage;
- (5) to make the best use of International Universal Health Coverage Day to drive the universal health coverage agenda, including by encouraging increased political commitment to universal health coverage;
- (6) to submit biennial reports on progress made in implementing this resolution, starting with the Seventy-third World Health Assembly in 2020 and ending with the Eighty-third World Health Assembly in 2030, as part of existing reporting on resolution WHA69.11 (2016).

(Sixth plenary meeting, 24 May 2019 –
Committee A, second report)

WHA72.5 Antimicrobial resistance¹

The Seventy-second World Health Assembly,

Having considered the report by the Director-General on follow-up to the high-level meetings of the United Nations General Assembly on health-related issues: antimicrobial resistance;²

Recalling United Nations General Assembly resolution 71/3 (2016), the political declaration of the high-level meeting of the General Assembly on antimicrobial resistance, and acknowledging the establishment of the Interagency Coordination Group on Antimicrobial Resistance to provide practical guidance and recommendations for necessary approaches to ensure sustained and effective global action to address antimicrobial resistance;

Recognizing the importance of addressing growing antimicrobial resistance to contribute to the achievement of the 2030 Agenda for Sustainable Development;

Reiterating the need to combat antimicrobial resistance through a coordinated, multisectoral, One Health approach;

Recalling resolution WHA68.7 (2015) in which the Health Assembly adopted the global action plan on antimicrobial resistance, which lays out five strategic objectives (improve awareness and understanding of antimicrobial resistance; strengthen knowledge through surveillance and research; reduce the incidence of infection; optimize the use of antimicrobial agents; and develop the economic case for sustainable investment), and noting the progress made in establishing the Global Antimicrobial Resistance Surveillance System (GLASS);

Recognizing the pressing need for investing in high-quality research and development, including basic research for antimicrobials, diagnostic technologies, vaccines and alternative preventive measures across sectors, and for ensuring adequate access to those in need of quality, safe, efficacious and affordable existing and new antimicrobials, diagnostic technologies and vaccines, while promoting effective stewardship;

¹ See Annex 9 for the financial and administrative implications for the Secretariat of this resolution.

² Document A72/18.

Acknowledging the threat posed by resistant pathogens to the continuing effectiveness of antimicrobials, especially for ending the epidemics of HIV/AIDS, tuberculosis, and malaria;

Acknowledging also the positive effect of immunization through vaccination, and of other infection prevention and control measures, such as adequate water, sanitation and hygiene (WASH), in reducing antimicrobial resistance;

Recognizing the need both to maintain the production capacity for relevant older antibiotics, and to promote their prudent use;

Recalling FAO resolution 4/2015 on antimicrobial resistance, OIE resolution No. 36 (2016) on combating antimicrobial resistance through a One Health approach: actions and OIE strategy, and the UNEP resolution UNEP/EA.3/Res.4 (2018) on environment and health;

Noting the importance of providing opportunities for Member States to engage meaningfully with and provide input into reports, recommendations, and relevant actions from WHO, FAO, and OIE, together with UNEP, and from the Interagency Coordination Group on Antimicrobial Resistance aimed at combating antimicrobial resistance;

Reaffirming the global commitment to combat antimicrobial resistance with continued, high-level political efforts as a coordinated international community, emphasizing the critical need to accelerate Member States' development and implementation of their national action plans with a One Health approach,

1. WELCOMES the new tripartite agreement on antimicrobial resistance, and encourages the Tripartite agencies (WHO, FAO, OIE) and UNEP to establish clear coordination for its implementation and to align reporting to their governing bodies on progress under the joint workplan, according to their respective mandates;

2. URGES Member States:¹

(1) to remain committed at the highest political level to combating antimicrobial resistance, using a One Health approach, and to reducing the burden of disease, mortality and disability associated with it;

(2) to increase efforts to implement the actions and attain the strategic objectives of the global action plan on antimicrobial resistance, and take steps to deal with emerging issues;

(3) to further enhance the prudent use of all antimicrobials, and consider developing and implementing clinical guidelines and criteria according to which critically important antimicrobials should be used, in accordance with national priorities and context, in order to slow the emergence of drug resistance and sustain the effectiveness of existing drugs;

(4) to conduct post-market surveillance of antimicrobials and take appropriate action to eliminate substandard and falsified antimicrobials;

(5) to strengthen efforts to develop, implement, monitor, and update, adequately resourced multisectoral national action plans;

¹ And, where applicable, regional economic integration organizations.

(6) to participate in the annual antimicrobial resistance country self-assessment survey administered by the Tripartite;

(7) to develop new or strengthen existing monitoring systems that will contribute to the annual antimicrobial resistance country self-assessment survey administered by the Tripartite and to participation in the Global Antimicrobial Resistance Surveillance System (GLASS), and to use this information to improve implementation of national action plans;

(8) to enhance cooperation at all levels for concrete action towards combating antimicrobial resistance, including through: health system strengthening; capacity-building, including for research and regulatory capacity; and technical support, including, where appropriate, through twinning programmes that build on best practices, emerging evidence and innovation;

(9) to support technology transfer on voluntary and mutually agreed terms for controlling and preventing antimicrobial resistance;

3. INVITES international, regional, and national partners, and other relevant stakeholders:

(1) to continue to support Member States in the development and implementation of multisectoral national action plans in line with the five strategic objectives of the global action plan on antimicrobial resistance;

(2) to coordinate efforts in order to avoid duplication and gaps and leverage resources more effectively;

(3) to increase efforts and enhance multistakeholder collaboration in order to develop and apply tools for addressing antimicrobial resistance following a One Health approach, including through coordinated, responsible, sustainable and innovative approaches to research and development, including but not limited to quality, safe, efficacious and affordable antimicrobials, and alternative medicines and therapies, vaccines and diagnostic tools, adequate water, sanitation and hygiene (WASH), including infection prevention and control measures;

(4) to consider antimicrobial resistance priorities in funding and programmatic decisions, including innovative ways to mainstream antimicrobial resistance-relevant activities into existing international development financing;

4. REQUESTS the Director-General:

(1) to accelerate the implementation of the actions of, and advance the principles defined in, the global action plan on antimicrobial resistance, through all levels of WHO, including through a comprehensive review to enhance current work in order to ensure that antimicrobial resistance activities are well coordinated, including those with relevant United Nations agencies and other relevant stakeholders, and that they are efficiently implemented across WHO;

(2) to significantly enhance support and technical assistance provided to countries in collaboration with relevant United Nations agencies for developing, implementing, and monitoring their multisectoral national action plans, with a specific focus on countries that have yet to finalize a multisectoral national action plan;

(3) to support Member States to develop and strengthen their integrated surveillance systems, including by emphasizing the need for national action plans to include the collection, reporting, and analysis of data on sales and use of antimicrobials as a deliverable that would be integrated into reporting on the WHO indicators;

- (4) to keep Member States regularly informed of WHO's work with the Tripartite and UNEP, as well as with other United Nations organizations, to ensure a coordinated effort on workstreams; and informed of their progress in developing and implementing multisectoral approaches;
- (5) to consult regularly with Member States, and other relevant stakeholders, to adjust the process and scope of the global development and stewardship framework,¹ considering the work of the Interagency Coordination Group on Antimicrobial Resistance in order to ensure a unified and non-duplicative effort;
- (6) to support Member States to mobilize adequate predictable and sustained funding and human and financial resources and investment through national, bilateral and multilateral channels to support the development and implementation of national action plans, research and development on existing and new antimicrobial medicines, diagnostics, and vaccines, and other technologies, and strengthening of related infrastructure, including through engagement with multilateral development banks and traditional and voluntary innovative financing and investment mechanisms, based on priorities and local needs set by governments and on ensuring public return on investment;²
- (7) to collaborate with the World Bank and other financial institutions, OECD, and regional economic communities, in order to continue to make and apply the economic case for sustainable investment in antimicrobial resistance;
- (8) to facilitate, in consultation with the United Nations Secretary-General and the Tripartite and UNEP, the development of a process to allow Member States to consider the Secretary-General's report requested in United Nations General Assembly resolution 71/3 (2016);
- (9) to maintain and systematically update the WHO list of Critically Important Antimicrobials for human medicine;
- (10) to submit consolidated biennial reports on progress achieved in implementing this resolution and resolution WHA68.7 (2015) to the Seventy-fourth, Seventy-sixth, and Seventy-eighth World Health Assemblies, incorporating this work into existing antimicrobial resistance reporting, in order to allow Member States to review and evaluate efforts made.

(Seventh plenary meeting, 28 May 2019 –
Committee A, third report)

WHA72.6 Global action on patient safety³

The Seventy-second World Health Assembly,

Having considered the report by the Director-General on patient safety: global action on patient safety,⁴

¹ As requested in paragraph 4(7) of resolution WHA68.7 and called for in paragraph 13 of the political declaration of the high-level Meeting of the General Assembly on antimicrobial resistance.

² Paragraph 12b of United Nations General Assembly resolution 71/3.

³ See Annex 9 for the financial and administrative implications for the Secretariat of this resolution.

⁴ Document A72/26.

Recalling resolution WHA55.18 (2002) on quality of care: patient safety, which urged Member States to “pay the closest possible attention to the problem of patient safety; and to establish and strengthen science-based systems, necessary for improving patients’ safety and the quality of health care”; recognizing that patient safety is a critical element of, and the foundation for, delivering quality health care; and welcoming the inclusion of the need for patient safety in the Thirteenth General Programme of Work, 2019–2023;

Recognizing that patient safety cannot be ensured without access to: safe infrastructure, technologies and medical devices, and their safe use by patients, who need to be well informed; and a skilled and committed health workforce, in an enabling and safe environment;

Noting that patient safety builds on quality, basic and continued education and training of health professionals that ensure that they have the adequate professional skills and competencies in their respective roles and functions;

Recognizing that access to safe, effective, quality and affordable medicines and other commodities, and their correct administration and use, also contribute to patient safety;

Noting the importance of hygiene for patient safety and the prevention of health care-associated infections, and for reducing antimicrobial resistance;

Noting further that ensuring patient safety is a key priority in providing quality health services and considering that all individuals should receive safe health services, regardless of where they are delivered;

Reaffirming the principle of “First do no harm” and recognizing the benefits to be gained from patient safety and the need to promote and improve patient safety across health systems at all levels, sectors and settings relevant to physical and mental health, especially at the level of primary health care, but also including, for example, emergency care, community care, rehabilitation and ambulatory care;

Recognizing that the safety of patients during the provision of health services that are safe and of high quality is a prerequisite for strengthening health care systems and making progress towards effective universal health coverage under Sustainable Development Goal 3 (Ensure healthy lives and promote health and well-being for all at all ages);

Acknowledging that instilling a safety culture, a patient-centred approach, and improving and ensuring patient safety require capacity-building, strong leadership, systemic and systematic approaches, adequate human and other resources, robust data, sharing of best practices, mutual learning, trust and accountability, which can be strengthened, as appropriate, by international cooperation and collaboration;

Recognizing that improving and ensuring patient safety is a growing challenge to health service delivery globally and that unsafe health care causes a significant level of avoidable patient harm and human suffering, places a considerable strain on health system finances and leads to a loss of trust in health systems;

Concerned that the burden of injuries and other harm to patients from adverse events is likely one of the top 10 causes of death and disability in the world, comparable to that of tuberculosis and malaria, and that available evidence suggests that most of this burden falls on low- and middle-income countries, where 134 million health care-associated adverse events occur annually in hospitals, due to unsafe care, contributing to 2.6 million deaths;

Recognizing that most adverse events can potentially be avoided with effective prevention and mitigation strategies, including, as appropriate, improved policies, data systems, redesigned processes of care (including addressing human factors, including training), environmental hygiene and infrastructure, better organizational culture to improve practices, supportive and effective regulatory systems and improved communication strategies, and that solutions can often be simple and inexpensive, with the value of prevention outweighing the cost of care;

Recognizing the success, pioneering work and dedication of governments in many Member States in developing strategies and policies to support and improve patient safety; in implementing safety and quality programmes, initiatives and interventions, such as insurance arrangements and patient ombudspersons; in creating a patient safety culture throughout the health system and transparent incident reporting systems that allow learning from mistakes, and in ensuring no-fault and no-blame handling of adverse events and their consequences; and in developing a patient-centred approach to patient safety;

Concerned at the lack of overall progress in improving the safety of health care and that, despite global efforts to reduce the burden of patient harm, the overall situation over the past 17 years indicates that significant improvement can be made and that safety measures – even those implemented in high-income settings – have had limited or varying impact, and that most have not been adapted for successful application in low- and middle-income countries;

Recognizing the importance of robust patient safety measurement to promote more resilient health systems, better and more focused preventive work to promote safety and risk awareness, transparent incident reporting, data analysis and learning systems, at all levels, alongside education, training and continuous professional development to build and maintain a competent, compassionate and committed health care workforce operating within a supportive environment to make health care safe, and the importance of engaging and empowering patients and families in improving the safety of care for better health outcomes;

Recognizing also that improving and ensuring patient safety calls for addressing the gaps in knowledge, policy, design, delivery and communication at all levels,

1. ENDORSES the establishment of World Patient Safety Day, to be marked annually on 17 September in order to increase public awareness and engagement, enhance global understanding, and work towards global solidarity and action by Member States to promote patient safety;
2. URGES Member States:¹
 - (1) to recognize patient safety as a health priority in health sector policies and programmes, making it an essential component for strengthening health care systems in order to achieve universal health coverage;
 - (2) to assess and measure the nature and magnitude of the problem of patient safety, including risks, errors, adverse events and patient harm at all levels of health service delivery, including through reporting, learning and feedback systems that incorporate the perspectives of patients and their families, and to take preventive action and implement systematic measures to reduce risks to all individuals;

¹ And, where applicable, regional economic integration organizations.

- (3) to develop and implement national policies, legislation, strategies, guidance and tools, and deploy adequate resources, in order to strengthen systems and ensure the safety of all health services, as appropriate;
- (4) to work in collaboration with other Member States, civil society organizations, patients' organizations, professional bodies, academic and research institutions, industry and other relevant stakeholders to promote, prioritize and embed patient safety in all health policies and strategies;
- (5) to share and disseminate best practices and encourage mutual learning to reduce patient harm through regional and international collaboration;
- (6) to integrate and implement patient safety strategies in all clinical programmes and risk areas, as appropriate, to prevent avoidable harm to patients related to health care procedures, products and devices, including in the areas of medication safety, surgical safety, infection control, sepsis management, diagnostic safety, environmental hygiene and infrastructure, injection safety, blood safety and radiation safety, as well as to minimize the risk of inaccurate or late diagnosis and treatment, and to pay special attention to at-risk groups;
- (7) to promote a safety culture by providing basic training to all health professionals, developing a blame-free patient safety incident reporting culture through open and transparent systems that identify, and learn from examining, causative and contributing factors of harm, addressing human factors, and building leadership and management capacity and efficient multidisciplinary teams, in order to increase awareness and ownership, improve outcomes for patients and reduce the costs related to adverse events at all levels of health systems;
- (8) to build sustainable human resource capacity, through multisectoral and interprofessional competency-based education and training, based on the WHO patient safety curricula and continuous professional development, to promote a multidisciplinary approach, and to build an appropriate working environment that optimizes the delivery of safe health services;
- (9) to promote research, including translational research, to support the provision of safer health services and long-term care;
- (10) to promote the use of new technologies, including digital technologies, for health, including to build and scale up health information systems and to support data collection for surveillance and reporting of risks, adverse events and other indicators of harm at different levels of health services and health-related social care, while ensuring the protection of personal data, and to support the use of digital solutions to provide safer health care;
- (11) to consider the use of traditional and complementary medicine, as appropriate, in the provision of safer health care;
- (12) to put in place systems for the engagement and empowerment of patients' families and communities (especially those who have been affected by adverse events) in the delivery of safer health care, including capacity-building initiatives, networks and associations, and to work with them and civil society, to use their experience of safe and unsafe care positively in order to build safety and harm-minimization strategies, as well as compensation mechanisms and schemes, into all aspects of the provision of health care, as appropriate;

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- (13) to mark World Patient Safety Day annually on 17 September to promote all aspects of patient safety including progress towards reaching national milestones, in collaboration with relevant stakeholders;
- (14) to consider participating in the annual Global Ministerial Summits on Patient Safety;
3. INVITES international organizations and other relevant stakeholders to collaborate with Member States in promoting and supporting patient safety initiatives, including marking World Patient Safety Day annually;
4. REQUESTS the Director-General:
- (1) to emphasize patient safety as a key strategic priority in WHO's work across the universal health coverage agenda;
 - (2) to develop normative guidance on minimum standards, policies, best practice and tools for patient safety, including on safety culture, human factors, hygienic infrastructure, clinical governance and risk management;
 - (3) to provide technical support to Member States, especially low- and middle-income countries, where appropriate and where requested, to help to build national capacities in their efforts to assess, measure and improve patient safety, in collaboration with professional associations, as appropriate, and to create a safety culture, as well as ensuring effective prevention of health care-associated harm, including infections, by building capacity in leadership and management, and open and transparent systems that identify and learn from the causes of harm;
 - (4) to provide support to Member States, on request, in establishing and/or strengthening patient safety surveillance systems;
 - (5) to strengthen global patient safety networks to share best practice and learning and foster international collaboration including through a global network of patient safety trainers, and to work with Member States, civil society organizations, patients' organizations, professional associations, academic and research institutions, industry and other relevant stakeholders in building safer health care systems;
 - (6) to provide, on request, technical support and normative guidance on the development of human resource capacity in Member States through interprofessional competency-based education and training based on WHO patient safety curricula, and, in consultation with Member States, develop "training-of-trainers" programmes for patient safety education and training, and develop global and regional networks of professional educational councils to promote education on patient safety;
 - (7) to develop and manage, in consultation with Member States, systems for global sharing of learning from patient safety incidents, including through reliable and systematic reporting, data analysis and dissemination systems;
 - (8) to design, launch and support Global Patient Safety Challenges', and to develop and implement strategies, guidance and tools to support Member States in implementing each Challenge, using the best available evidence;
 - (9) to promote and support the application of digital technologies and research, including translational research for improving the safety of patients;

(10) to provide support to Member States, upon request, in putting into place systems to support the active engagement, participation and empowerment of patients, families and communities in the delivery of safer health care, and in establishing and strengthening networks for engagement of patients, communities, civil society and patient associations;

(11) to work with Member States, international organizations and other relevant stakeholders to promote World Patient Safety Day;

(12) to formulate a global patient safety action plan in consultation with Member States¹ and all relevant stakeholders, including in the private sector, for submission to the Seventy-fourth World Health Assembly in 2021 through the Executive Board at its 148th session;

(13) to submit a report on progress in the implementation of this resolution, for the consideration of the Seventy-fourth, Seventy-sixth and Seventy-eighth World Health Assemblies.

(Seventh plenary meeting, 28 May 2019 –
Committee A, fifth report)

WHA72.7 Water, sanitation and hygiene in health care facilities²

The Seventy-second World Health Assembly,

Having considered the report on patient safety: water, sanitation and hygiene in health care facilities;³

Recalling the Declaration of Astana endorsed at the Global Conference on Primary Health Care (Astana, Kazakhstan, 25 and 26 October 2018) which envisages strengthening primary health care as the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being, and that primary health care is a cornerstone of a sustainable health system for universal health coverage and health-related Sustainable Development Goals;

Recalling also resolution WHA64.24 (2011) on drinking water, sanitation and health, which emphasizes the tenets of primary health care as set out in the Declaration of Alma-Ata on Primary Health Care and other resolutions recalled therein (WHA35.17 (1982), WHA39.20 (1986), WHA42.25 (1989), WHA44.28 (1991), WHA45.31 (1992), WHA51.28 (1998) and WHA63.23 (2010)) and resolution WHA70.7 (2017) on improving the prevention, diagnosis and clinical management of sepsis, which stressed the role of improving safe drinking water, sanitation facilities, health care waste management and hygiene practices in primary health care;

Recalling further United Nations General Assembly resolution 64/292 (2010) on the human right to water and sanitation, and General Assembly resolution 72/178 (2017) and the United Nations Human Rights Council resolution 39/8 (2018), both on the human rights to safe drinking water and sanitation;

Noting that without sufficient and safe water, sanitation and hygiene services in health care facilities, countries will not achieve the targets set out in Sustainable Development Goal 3 (Ensure healthy lives and promote health and well-being for all at all ages) and Goal 6 (Ensure availability and sustainable management of water and sanitation for all), including reducing maternal and newborn

¹ And, where applicable, regional economic integration organizations.

² See Annex 9 for the financial and administrative implications for the Secretariat of this resolution.

³ Document A72/27.

mortality and achieving effective universal health coverage, and those in Sustainable Development Goals 1 (End poverty in all its forms everywhere), 7 (Ensure access to affordable, reliable, sustainable and modern energy for all.), 11 (Make cities and human settlements inclusive, safe, resilient and sustainable) and 13 (Take urgent action to combat climate change and its impacts);

Noting also that the provision of safe water, sanitation and hygiene services is fundamental for patient safety and has been shown to reduce the risk of infection for patients, carers, health workers and surrounding communities, and noting that progress towards the provision of those services in health care facilities would also allow for effective and timely prevention of cholera, and care for patients with the disease, in addition to diarrhoeal and other diseases, as recognized in resolution WHA71.4 (2018) on cholera prevention and control;

Recalling resolution WHA68.7 (2015) on the global action plan on antimicrobial resistance, the objectives of which underscore the critical importance of safe water, sanitation and hygiene services in community and health care settings for better hygiene and infection prevention measures to limit the development and spread of antimicrobial-resistant infections and to limit the inappropriate use of antimicrobial medicines, ensuring good stewardship;

Noting the findings of the joint WHO and UNICEF report, *WASH in health care facilities: global baseline report 2019*,¹ which revealed that one in four health care facilities lack basic water services, one in five have no sanitation service and 42% have no hygiene facilities at point of care; underscoring the implications of not having these basics in these places, including the spread of infections in places that are supposed to promote health and basic hygiene for disease prevention; and stressing the implications for the dignity of patients and other users who seek health care services, particularly women in labour and their newborn babies;

Recalling the statement of the United Nations Secretary-General, at the launch of the International Decade for Action 2018-2028 – Water for Sustainable Development, making a global call for action for water, sanitation and hygiene in all health care facilities;

Noting that the Director-General's report to the Seventy-first World Health Assembly on health, environment and climate change² identified global driving forces, including population growth, urbanization and climate change, which are expected to significantly affect the availability and quality of, and access to, water and sanitation services and freshwater resources, and the urgent need for addressing the links between climate, energy, safe water, sanitation and hygiene and health;

1. URGES Member States:³

- (1) to conduct comprehensive assessments according to the national context and, where appropriate, to quantify: the availability and quality of, and needs for, safe water, sanitation and hygiene in health care facilities; and infection prevention and control status, using existing

¹ *WASH in health care facilities: global baseline report 2019*. Geneva: World Health Organization and the United Nations Children's Fund; 2019.

² Document A71/11.

³ And, where applicable, regional economic integration organizations.

regional and global protocols or tools^{1,2} and in collaboration with the global effort to improve provision of safe water, sanitation and hygiene in health care facilities;³

(2) to develop and implement a road map according to national context so that every health care facility in every setting has, commensurate with its needs: safely managed and reliable water supplies; sufficient, safely managed and accessible toilets or latrines for patients, caregivers and staff of all sexes, ages and abilities; appropriate core components of infection prevention and control programmes, including good hand hygiene infrastructure and practices; routine, effective cleaning; safe waste management systems, including those for excreta and medical waste disposal; and, whenever possible, sustainable and clean energy;

(3) to establish and implement, according to national context, minimum standards for safe water, sanitation and hygiene and infection prevention and control in all health care settings, and build standards for safe water, sanitation and hygiene and infection prevention and control into accreditation and regulation systems; and to establish accountability mechanisms to reinforce standards and practice;

(4) to set targets within health policies and integrate indicators for safe water, sanitation and hygiene and infection prevention and control⁴ into national monitoring mechanisms to establish baselines, track progress, and track health system performance on a regular basis;

(5) to integrate safe water, sanitation and hygiene into health programming, including into nutrition and maternal, child and newborn health within the context of safe, quality and integrated people-centred health services, effective universal health coverage, infection prevention and control, and containment of antimicrobial resistance;

(6) to identify and address inequities and interruptions in the availability of adequate safe water, sanitation and hygiene services in health facilities, especially in facilities that provide maternity services and in primary health care facilities;

(7) to align their strategies and approaches with the global effort for safe water, sanitation and hygiene in health care facilities⁵ and contribute to the realization of Sustainable Development Goal 3 (Ensure healthy lives and promote health and well-being for all at all ages) and Goal 6 (Ensure availability and sustainable management of water and sanitation for all);

¹ WHO and UNICEF. Water and sanitation for health facility improvement tool (WASH FIT): a practical guide for improving quality of care through water, sanitation and hygiene in health care facilities. Geneva: World Health Organization; 2017 (https://www.who.int/water_sanitation_health/publications/water-and-sanitation-for-health-facility-improvement-tool/en/, accessed 4 September 2019).

² WHO. National infection prevention and control assessment tool (IPCAT2) and Infection Prevention and Control Assessment Framework at the Facility Level (IPCAF), see <https://www.who.int/infection-prevention/tools/core-components/en/> and links therein (accessed 7 February 2019).

³ WHO and UNICEF are jointly coordinating the global efforts to improve safe water, sanitation and hygiene (WASH) in health care facilities. Action is focused on a number of key areas, including national assessments. More information can be found on the knowledge portal on WASH in health care facilities – global action to provide universal access by 2030: www.washinhc.org (accessed 7 February 2019).

⁴ WHO and UNICEF. Core questions and indicators for monitoring WASH in health care facilities in the Sustainable Development Goals. Geneva: World Health Organization; 2018 (https://www.who.int/water_sanitation_health/publications/core-questions-and-indicators-for-monitoring-wash/en/, accessed 7 February 2019).

⁵ Details of WHO/UNICEF global activities on WASH in health care facilities available at https://www.who.int/water_sanitation_health/facilities/en/ (accessed 7 February 2019).

(8) to have procedures and funding in place to operate and maintain services for safe water, sanitation and hygiene and for infection prevention and control in health facilities, and to make continuous upgrades and improvements based on needs so that infrastructure continues to operate and resources are made available to help facilities to access other sources of safe water in the event of failures in the normal water supply, so that environmental and other impacts are minimized and in order to maintain hygiene practices;

(9) to educate and raise awareness, in line with regional agreements, on water, sanitation and hygiene, with a particular focus on maternity, hospital facilities and settings used by mothers and children; and to conduct ongoing education campaigns on the risks of poor sanitation, including open defecation, to discourage this practice and encourage community support for use of toilets and safe management of faecal waste by health workers;

(10) to establish strong multisectoral coordination mechanisms with the active involvement of all relevant ministries, particularly those responsible for health, finance, water and energy; to align and strengthen collaborative efforts and ensure adequate financing to support the delivery of all aspects of safe water, sanitation and hygiene and infection prevention and control across the health system; and to invest in an adequately sized and well-trained health workforce (including health care workers, cleaners and engineers to manage safe water, sanitation and hygiene services, provide ongoing maintenance and operations and perform appropriate safe water, sanitation and hygiene and infection prevention and control practices) including investing in strong pre-service and ongoing in-service education and training programmes for all levels of staff;

(11) to promote a safe and secure working environment for every health worker, including working aids and tools, safe water, sanitation and hygiene services and cleaning and hygiene supplies, for efficient and safe service delivery;

2. INVITES international, regional and local partners:

(1) to raise the profile of safe water, sanitation and hygiene and infection prevention and control in health care facilities, in health strategies and in flexible funding mechanisms, and thereby direct efforts towards strengthening health systems as a whole, rather than focusing on vertical or siloed programming approaches;

(2) to support governments' efforts to empower communities to participate in the decision-making concerning the provision of better and more equitable safe water, sanitation and hygiene services in health facilities, including their reporting to authorities about insufficient or inadequate safe water, sanitation and hygiene services;

3. REQUESTS the Director-General:

(1) to continue to provide global leadership and pursue the development of technical guidance to achieve the targets set out in this resolution;

(2) to report on the global status of access to safe water, sanitation and hygiene in health care facilities as part of efforts to achieve Sustainable Development Goal 6 (Ensure availability and sustainable management of water and sanitation for all), including through the Joint Monitoring Programme, and to include safe water, sanitation and hygiene and infection prevention and control in health care facilities within effective universal health coverage, primary health care and efforts to monitor the quality of care;

- (3) to catalyse the mobilization of domestic and external resources from the public and private sectors, and to support the development of national business cases for investment in safe water, sanitation and hygiene and infection prevention and control in health care facilities;
- (4) to continue to raise the profile of safe water, sanitation and hygiene and infection prevention and control in health care facilities within WHO and at high-level political forums, and to work with other United Nations agencies in order to respond to the United Nations Secretary-General's call to action in a coordinated manner;
- (5) to work with Member States and partners to review, update and implement the global action plan on antimicrobial resistance and support Member States in the development of national road maps and targets for safe water, sanitation and hygiene in health care facilities;
- (6) to work with partners to adapt existing reporting mechanisms and, if necessary, develop new such mechanisms in order to capture and monitor progress on the coordination, implementation, financing, access, quality and governance of safe water, sanitation and hygiene and infection prevention and control in health care facilities, according to the established indicator reporting methodology for Sustainable Development Goal 6 (Ensure availability and sustainable management of water and sanitation for all);¹
- (7) to support implementation and coordination of safe water, sanitation and hygiene and basic infection prevention and control measures in health care facilities and triage centres in times of crisis and humanitarian emergencies through the Health and WASH clusters, leveraging partnerships to prevent disease outbreaks in these contexts;
- (8) to report on progress in the implementation of the present resolution to the Health Assembly in 2021 and 2023.

(Seventh plenary meeting, 28 May 2019 –
Committee A, fifth report)

WHA72.8 Improving the transparency of markets for medicines, vaccines, and other health products^{2,3}

The Seventy-second World Health Assembly,

Having considered the report by the Director-General on access to medicines and vaccines⁴ and its annex entitled “draft road map for access to medicines, vaccines, and other health products, 2019–2023” and the report by the Director-General on medicines, vaccines and health products: cancer medicines,⁵ pursuant to resolution WHA70.12 (2017) on cancer prevention and control in the context of an integrated approach;

¹ Includes protocols, methods and reporting conducted by the WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene and the WHO-led UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water.

² For the purposes of this resolution, health products include medicines, vaccines, medical devices, diagnostics, assistive products, cell- and gene-based therapies, and other health technologies.

³ See Annex 9 for the financial and administrative implications for the Secretariat of this resolution.

⁴ Document A72/17.

⁵ Document EB144/18.

Recognizing the critical role played by health products¹ and services innovation in bringing new treatments and value to patients and health care systems around the world;

Recognizing also that improving access to health products is a multidimensional challenge that requires action across, and adequate knowledge of, the entire value chain and life cycle, from research and development to quality assurance, regulatory capacity, supply chain management and use;

Seriously concerned about high prices for some health products, and inequitable access to such products within and among Member States, as well as the financial hardships associated with high prices, which impede progress towards achieving universal health coverage;

Recognizing that the types of information publicly available on data across the value chain of health products, including prices effectively paid by different actors and costs, vary among Member States and that the availability of comparable price information may facilitate efforts towards affordable and equitable access to health products;

Seeking to enhance the publicly available information on the prices applied in different sectors and in different countries, and the access to and use of this information, while recognizing different national and regional legal frameworks and contexts and acknowledging the importance of differential pricing;

Taking note of the productive discussions at the second Fair Pricing Forum (Johannesburg, South Africa, 11–13 April 2019) regarding the promotion of greater transparency around prices of health products, especially through sharing of information to stimulate the development of functional and competitive global markets;

Noting the importance of both public- and private-sector funding for research and development of health products, and seeking to improve the transparency of such funding across the value chain;

Seeking to progressively enhance the publicly available information on inputs across the value chain of health products, the public reporting of the relevant patents and their status, and the availability of information on the patents landscape covering a particular health product as well as its marketing approval status;

Noting the latest World Medical Association Declaration of Helsinki (2013), which promotes making publicly available the results of clinical trials, including negative and inconclusive as well as positive results, and noting that public access to comprehensive data on clinical trials is important for promoting advancement in science and successful treatment of patients, while protecting personal patient information;

Agreeing that policies that influence the pricing of health products and that reduce barriers to access can be better formulated and evaluated when there are reliable, comparable, transparent and sufficiently detailed data² across the value chain,

¹ For the purposes of this resolution, health products include medicines, vaccines, medical devices, diagnostics, assistive products, cell- and gene-based therapies, and other health technologies.

² Including but not limited to data on: availability, especially in small markets; units sold and patients reached in different markets; and the medical benefits and added therapeutic value of these products.

1. URGES Member States in accordance with their national and regional legal frameworks and contexts:

- (1) to take appropriate measures to publicly share information on the net prices¹ of health products;
- (2) to take the necessary steps, as appropriate, to support dissemination and enhanced availability of, and access to, aggregated results data and, if already publicly available or voluntarily provided, costs from human subject clinical trials regardless of outcomes or whether the results will support an application for marketing approval, while ensuring patient confidentiality;
- (3) to work collaboratively to improve the reporting of information by suppliers on registered health products, such as reports on sales revenues, prices, units sold, marketing costs, and subsidies and incentives;
- (4) to facilitate improved public reporting of patent status information and the marketing approval status of health products;
- (5) to improve national capacities in the area of health products, including through international cooperation and open and collaborative research and development and production of health products, especially in developing countries and low- and middle-income countries, including health products for the diseases that primarily affect them, as well as capacities for product selection, cost-effective procurement, quality assurance, and supply chain management;

2. REQUESTS the Director-General to:

- (1) to continue to support Member States, upon their request, in collecting and analysing information on economic data across the value chain for health products and data for relevant policy development and implementation towards achieving universal health coverage;
- (2) to continue supporting Member States, especially low- and middle-income countries, in developing and implementing their national policies relevant to the transparency of markets for health products, including national capacities for local production, rapid and timely adoption of generic and biosimilar products, cost-effective procurement, product selection, quality assurance and supply-chain management of health products;
- (3) to support research on price transparency and monitor its impact on affordability and availability of health products, including its effect on differential pricing, especially in low- and middle-income countries and small markets, and provide analysis and support to Member States in this regard as appropriate;
- (4) to analyse the availability of data on inputs throughout the value chain, including data on clinical trials and price information, with a view to assessing the feasibility and potential value of establishing a web-based tool to share information relevant to the transparency of markets for health products, including information on investments, incentives, and subsidies;

¹ For the purposes of this resolution, “net price,” “effective price,” “net transaction price” or “manufacturer selling price” are the amount received by manufacturers after subtraction of all rebates, discounts, and other incentives.

(5) to continue WHO's efforts to biennially convene the Fair Pricing Forum with Member States and all relevant stakeholders to discuss the affordability and transparency of prices and costs relating to health products;

(6) to continue supporting existing efforts to determine the patent status of health products and promote publicly available, user-friendly patent status information databases for public health actors, in line with the global strategy and plan of action on public health, innovation and intellectual property, and to work with other relevant international organizations and stakeholders to improve international cooperation, avoid duplication of work, and promote relevant initiatives;

(7) to submit a report on progress made to the Seventy-fourth World Health Assembly, through the Executive Board at its 148th session.

(Seventh plenary meeting, 28 May 2019 –
Committee A, seventh report)

WHA72.9 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution

The Seventy-second World Health Assembly,

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

Having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-second World Health Assembly;²

Noting that, at the time of opening of the Seventy-second World Health Assembly, the voting rights of the Central African Republic,³ Comoros, Gambia, Guinea-Bissau, South Sudan, Ukraine, and Venezuela (Bolivarian Republic of)⁴ were suspended, such suspension to continue until the arrears of the Member States concerned have been reduced, at the present or future Health Assemblies, to a level below the amount that would justify invoking Article 7 of the Constitution;

Noting that Congo and Senegal were in arrears at the time of the opening of the Seventy-second World Health Assembly to such an extent that it was necessary for the Health Assembly to consider, in accordance with Article 7 of the Constitution, whether the voting privileges of those countries should be suspended at the opening of the Seventy-third World Health Assembly in 2020,

DECIDES:

(1) that, in accordance with the statement of principles set out in resolution WHA41.7 (1988), if, by the time of the opening of the Seventy-third World Health Assembly, Congo and Senegal

¹ Document A72/37.

² Document A72/66.

³ See document A72/61.

⁴ See document A72/60 Rev.1.

are still in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution, their voting privileges shall be suspended as from the said opening;

(2) that any suspension that takes effect as set out in paragraph (1) above shall continue at the Seventy-third World Health Assembly and subsequent Health Assemblies, until the arrears of Congo and Senegal have been reduced to a level below the amount that would justify invoking Article 7 of the Constitution;

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

(Seventh plenary meeting, 28 May 2019 –
Committee B, second report)

WHA72.10 Special arrangements for settlement of arrears: Central African Republic

The Seventy-second World Health Assembly,

Having considered the request of the Central African Republic in respect of its outstanding contributions up to and including 2018 of US\$ 134 646; considering also the request of the Central African Republic to reschedule payment of this balance over the period 2019–2028;

Noting that this request did not comply fully with the requirements of resolution WHA54.6 (2001) as to timing and procedure,

1. DECIDES to restore the Central African Republic's voting privileges at the Seventy-second World Health Assembly on the following conditions:

The Central African Republic shall pay its outstanding arrears of assessed contributions, totalling US\$ 134 646 over 10 years from 2019 to 2028, as set out below, in addition to its annual assessment;

Year	US\$
2019	13 465
2020	13 465
2021	13 465
2022	13 465
2023	13 465
2024	13 465
2025	13 465
2026	13 465
2027	13 465
2028	13 461
Total	134 646

2. FURTHER DECIDES that, in accordance with Article 7 of the Constitution, the Central African Republic's voting privileges shall be automatically suspended if it does not meet the requirements laid down in paragraph 1 above;

3. REQUESTS the Director-General to report to future Health Assemblies, as appropriate, on the prevailing situation;
4. FURTHER REQUESTS the Director-General to communicate this resolution to the Government of the Central African Republic.

(Seventh plenary meeting, 28 May 2019 –
Committee B, second report)

WHA72.11 Appointment of the External Auditor

The Seventy-second World Health Assembly,

Having considered the report by the Director-General on the appointment of the External Auditor,¹

1. RESOLVES that the Comptroller and Auditor General of India shall be appointed External Auditor of the accounts of the World Health Organization for the four-year period from 2020 to 2023 and that he/she shall audit in accordance with the principles incorporated in Regulation XIV of the Financial Regulations and the Appendix to the Financial Regulations, and that, should the necessity arise, he/she may designate a representative to act in his/her absence;
2. EXPRESSES its thanks to the Commission on Audit of the Republic of the Philippines for the work it has performed for the Organization in auditing the accounts for the eight-year period from 2012 to 2019.

(Seventh plenary meeting, 28 May 2019 –
Committee B, second report)

WHA72.12 Scale of assessments for 2020–2021

The Seventy-second World Health Assembly,

Having considered the report by the Director-General on the scale of assessments for 2020–2021,²

ADOPTS the scale of assessments of Members and Associate Members for the biennium 2020–2021 as set out below.

Members and Associate Members	WHO scale for 2020–2021 %
Afghanistan	0.0070
Albania	0.0080
Algeria	0.1380
Andorra	0.0050
Angola	0.0100
Antigua and Barbuda	0.0020
Argentina	0.9151
Armenia	0.0070

¹ Document A72/42.

² Document A72/38.

Members and Associate Members	WHO scale for 2020–2021 %
Australia	2.2101
Austria	0.6770
Azerbaijan	0.0490
Bahamas	0.0180
Bahrain	0.0500
Bangladesh	0.0100
Barbados	0.0070
Belarus	0.0490
Belgium	0.8211
Belize	0.0010
Benin	0.0030
Bhutan	0.0010
Bolivia (Plurinational State of)	0.0160
Bosnia and Herzegovina	0.0120
Botswana	0.0140
Brazil	2.9482
Brunei Darussalam	0.0250
Bulgaria	0.0460
Burkina Faso	0.0030
Burundi	0.0010
Cabo Verde	0.0010
Cambodia	0.0060
Cameroon	0.0130
Canada	2.7342
Central African Republic	0.0010
Chad	0.0040
Chile	0.4070
China	12.0058
Colombia	0.2880
Comoros	0.0010
Congo	0.0060
Cook Islands (not a member of the United Nations)	0.0010
Costa Rica	0.0620
Côte d'Ivoire	0.0130
Croatia	0.0770
Cuba	0.0800
Cyprus	0.0360
Czechia	0.3110
Democratic People's Republic of Korea	0.0060
Democratic Republic of the Congo	0.0100
Denmark	0.5540
Djibouti	0.0010
Dominica	0.0010
Dominican Republic	0.0530
Ecuador	0.0800
Egypt	0.1860

Members and Associate Members	WHO scale for 2020–2021 %
El Salvador	0.0120
Equatorial Guinea	0.0160
Eritrea	0.0010
Estonia	0.0390
Eswatini	0.0020
Ethiopia	0.0100
Fiji	0.0030
Finland	0.4210
France	4.4273
Gabon	0.0150
Gambia	0.0010
Georgia	0.0080
Germany	6.0904
Ghana	0.0150
Greece	0.3660
Grenada	0.0010
Guatemala	0.0360
Guinea	0.0030
Guinea-Bissau	0.0010
Guyana	0.0020
Haiti	0.0030
Honduras	0.0090
Hungary	0.2060
Iceland	0.0280
India	0.8341
Indonesia	0.5430
Iran (Islamic Republic of)	0.3980
Iraq	0.1290
Ireland	0.3710
Israel	0.4900
Italy	3.3072
Jamaica	0.0080
Japan	8.5645
Jordan	0.0210
Kazakhstan	0.1780
Kenya	0.0240
Kiribati	0.0010
Kuwait	0.2520
Kyrgyzstan	0.0020
Lao People's Democratic Republic	0.0050
Latvia	0.0470
Lebanon	0.0470
Lesotho	0.0010
Liberia	0.0010
Libya	0.0300
Lithuania	0.0710
Luxembourg	0.0670

Members and Associate Members	WHO scale for 2020–2021 %
Madagascar	0.0040
Malawi	0.0020
Malaysia	0.3410
Maldives	0.0040
Mali	0.0040
Malta	0.0170
Marshall Islands	0.0010
Mauritania	0.0020
Mauritius	0.0110
Mexico	1.2921
Micronesia (Federated States of)	0.0010
Monaco	0.0110
Mongolia	0.0050
Montenegro	0.0040
Morocco	0.0550
Mozambique	0.0040
Myanmar	0.0100
Namibia	0.0090
Nauru	0.0010
Nepal	0.0070
Netherlands	1.3561
New Zealand	0.2910
Nicaragua	0.0050
Niger	0.0020
Nigeria	0.2500
Niue (not a member of the United Nations)	0.0010
North Macedonia	0.0070
Norway	0.7540
Oman	0.1150
Pakistan	0.1150
Palau	0.0010
Panama	0.0450
Papua New Guinea	0.0100
Paraguay	0.0160
Peru	0.1520
Philippines	0.2050
Poland	0.8021
Portugal	0.3500
Puerto Rico (not a member of the United Nations)	0.0010
Qatar	0.2820
Republic of Korea	2.2671
Republic of Moldova	0.0030
Romania	0.1980
Russian Federation	2.4052
Rwanda	0.0030

Members and Associate Members	WHO scale for 2020–2021 %
Saint Kitts and Nevis	0.0010
Saint Lucia	0.0010
Saint Vincent and the Grenadines	0.0010
Samoa	0.0010
San Marino	0.0020
Sao Tome and Principe	0.0010
Saudi Arabia	1.1721
Senegal	0.0070
Serbia	0.0280
Seychelles	0.0020
Sierra Leone	0.0010
Singapore	0.4850
Slovakia	0.1530
Slovenia	0.0760
Solomon Islands	0.0010
Somalia	0.0010
South Africa	0.2720
South Sudan	0.0060
Spain	2.1461
Sri Lanka	0.0440
Sudan	0.0100
Suriname	0.0050
Sweden	0.9061
Switzerland	1.1511
Syrian Arab Republic	0.0110
Tajikistan	0.0040
Thailand	0.3070
Timor-Leste	0.0020
Togo	0.0020
Tokelau (not a member of the United Nations)	0.0010
Tonga	0.0010
Trinidad and Tobago	0.0400
Tunisia	0.0250
Turkey	1.3711
Turkmenistan	0.0330
Tuvalu	0.0010
Uganda	0.0080
Ukraine	0.0570
United Arab Emirates	0.6160
United Kingdom of Great Britain and Northern Ireland	4.5673
United Republic of Tanzania	0.0100
United States of America	22.0000
Uruguay	0.0870
Uzbekistan	0.0320
Vanuatu	0.0010

Members and Associate Members	WHO scale for 2020–2021 %
Venezuela (Bolivarian Republic of)	0.7280
Viet Nam	0.0770
Yemen	0.0100
Zambia	0.0090
Zimbabwe	0.0050
Total	100.0000

(Seventh plenary meeting, 28 May 2019 –
Committee B, second report)

WHA72.13 Salaries of staff in ungraded positions and of the Director-General¹

The Seventy-second World Health Assembly,

Noting the recommendations of the Executive Board with regard to remuneration of staff in ungraded posts and of the Director-General,²

1. ESTABLISHES the salaries of Assistant Directors-General and Regional Directors at US\$ 179 948 gross per annum with a corresponding net salary of US\$ 134 266;
2. ESTABLISHES the salary of the Deputy Directors-General at US\$ 198 315 gross per annum with a corresponding net salary of US\$ 146 388;
3. ESTABLISHES the salary of the Director-General at US\$ 244 571 gross per annum with a corresponding net salary of US\$ 176 917;
4. DECIDES that those adjustments in remuneration shall take effect from 1 January 2019.

(Seventh plenary meeting, 28 May 2019 –
Committee B, third report)

WHA72.14 Special arrangements for settlement of arrears: Bolivarian Republic of Venezuela

The Seventy-second World Health Assembly,

Having considered the request of the Bolivarian Republic of Venezuela in respect of its outstanding contributions up to and including 2019 of US\$ 13 219 535; considering also the request of the Bolivarian Republic of Venezuela to reschedule payment of this balance over the period 2019–2038;³

¹ See Annex 9 for the financial and administrative implications for the Secretariat of this resolution.

² See document A72/45.

³ See document A72/60 Rev.1.

Having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-second World Health Assembly;¹

Noting that this request did not comply fully with the requirements of resolution WHA54.6 (2001) as to timing and procedure,

1. DECIDES to restore the Bolivarian Republic of Venezuela's voting privileges at the Seventy-second World Health Assembly on the following conditions:

The Bolivarian Republic of Venezuela shall pay its outstanding arrears of assessed contributions, totalling US\$ 13 219 535 over 20 years from 2019 to 2038, as set out below, in addition to its annual assessment;

Year	US\$
2019	660 977
2020	660 977
2021	660 977
2022	660 977
2023	660 977
2024	660 977
2025	660 977
2026	660 977
2027	660 977
2028	660 977
2029	660 977
2030	660 977
2031	660 977
2032	660 977
2033	660 977
2034	660 977
2035	660 977
2036	660 977
2037	660 977
2038	660 972
Total	13 219 535

2. FURTHER DECIDES that, in accordance with Article 7 of the Constitution, the Bolivarian Republic of Venezuela's voting privileges shall be automatically suspended if it does not meet the requirements laid down in paragraph 1 above;

3. REQUESTS the Director-General to report to future Health Assemblies, as appropriate, on the prevailing situation;

¹ Document A72/66.

4. FURTHER REQUESTS the Director-General to communicate this resolution to the Government of the Bolivarian Republic of Venezuela.

(Seventh plenary meeting, 28 May 2019 –
Committee B, third report)

WHA72.15 Eleventh revision of the International Classification of Diseases¹

The Seventy-second World Health Assembly,

Having considered the reports of the Director-General on the eleventh revision of the International Classification of Diseases;²

Recalling the WHO Nomenclature Regulations adopted by the Twentieth World Health Assembly on 22 May 1967;³

Recalling also the resolution of the Forty-third World Health Assembly on 17 May 1990, adopting the tenth revision of the International Classification of Diseases with effect from 1 January 1993;⁴

Acknowledging that development and maintenance of the International Classification of Diseases is a core normative function of WHO,

1. ADOPTS the eleventh revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-11), to come into effect on 1 January 2022, subject to transitional arrangements, with the following constituents:

- (1) the detailed list of four-character categories and optional five- and six-character subcategories⁵ with the short tabulation lists for mortality and morbidity;
- (2) the definitions, standards and reporting requirements related to maternal, fetal, perinatal, neonatal and infant mortality;⁶
- (3) the rules and instructions for underlying cause coding for mortality and main condition coding for morbidity;

2. REQUESTS the Director-General:

- (1) to allocate sufficient resources within the Organization for the regular updating and maintenance of ICD-11 and its eventual revision;

¹ See Annex 9 for the financial and administrative implications for the Secretariat of this resolution.

² Documents A72/29 and A72/29 Add.1.

³ Resolution WHA20.18.

⁴ Resolution WHA43.24.

⁵ See ICD-11 browser at <https://icd.who.int/browse11/l-m/en> (accessed 28 March 2019).

⁶ Available at <https://icd.who.int/docs/norms-eb2019.pdf> (page 14, accessed 28 March 2019).

- (2) to publish the ICD-11 in the six official languages of the Organization and put in place the digital tools and support mechanisms for its maintenance, dissemination and use, including facilitation of linkages with existing clinical terminologies;
- (3) to provide support upon request to Member States in implementing ICD-11, including in building systems and capacity, and by providing the ICD-11 translation platform;
- (4) to provide transitional arrangements from 1 January 2022 for at least five years, and as long as necessary to enable Member States to compile and report statistics using previous revisions of the International Classification of Diseases;
- (5) to implement a regular updating process for ICD-11,¹ and to further develop and implement the family of disease- and health-related classifications, with the International Statistical Classification of Diseases and Related Health Problems as the core classification linked to other related classifications, specialty versions and terminologies;
- (6) to report on progress in implementing this resolution to the Seventy-sixth World Health Assembly in 2023, the Eightieth World Health Assembly in 2027, and the Eighty-fifth World Health Assembly in 2032, and to include in the 2032 report an assessment of the need for revision of ICD-11.

(Seventh plenary meeting, 28 May 2019 –
Committee B, fourth report)

WHA72.16 Emergency care systems for universal health coverage: ensuring timely care for the acutely ill and injured²

The Seventy-second World Health Assembly,

Having considered the report on emergency care systems for universal health coverage: ensuring timely care for the acutely ill and injured;³

Noting the importance of the organization of the health system as a whole, including by distinguishing between elective services and care, non-elective services and care, and emergency services and care in order to address the health needs of populations in a sustainable, effective and appropriate manner;

Recognizing that many proven health interventions are time-dependent and that emergency care is an integrated platform for delivering accessible, quality and time-sensitive health care services for acute illness and injury across the life course;

Emphasizing that timeliness is an essential component of quality, and that millions of deaths and long-term disabilities from injuries, infections, mental disorders and other mental health conditions, acute exacerbations of noncommunicable diseases, acute complications of pregnancy, and other

¹ As described in Annex 3.8 of the Reference Guide of the ICD-11 (available at <https://icd.who.int/icd11refguide/en/index.html>, accessed 28 March 2019).

² See Annex 9 for the financial and administrative implications for the Secretariat of this resolution.

³ Document A72/31.

emergency conditions can be prevented each year if emergency care services exist and patients reach them in time;

Noting that injury alone accounts for nearly 5 million deaths per year and that road traffic injury is the top killer of all those in the age group of 5–29 years;¹

Noting also that emergency care is an essential part of health service delivery in health systems, and that well designed emergency services facilitate timely recognition, treatment management and, when needed, continued treatment of the acutely ill at the appropriate level of the health system;

Acknowledging Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages), and recognizing that well organized, safe and high-quality emergency care is a key mechanism for achieving a range of associated targets – including those on universal health coverage, road safety, maternal and child health, noncommunicable diseases, mental health, and infectious disease;

Acknowledging further Sustainable Development Goal 11 (Make cities and human settlements inclusive, safe, resilient and sustainable) and Goal 16 (Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels), and noting that a strong and well prepared everyday emergency care system is vital for mitigating the impact of disasters and mass casualty events and for maintaining delivery of health services in fragile situations and conflict-affected areas;

Recalling resolutions WHA56.24 (2003) on implementing the recommendations of the *World report on violence and health*, WHA57.10 (2004) on road safety and health (echoed by United Nations General Assembly resolution 72/271 (2018) on improving global road safety), WHA60.22 (2007) on health systems: emergency-care systems, WHA64.10 (2011) on strengthening national health emergency and disaster management capacities and resilience of health systems, WHA66.8 (2013) on the comprehensive global mental health action plan 2013–2020, WHA68.15 (2015) on strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage, and WHA69.1 (2016) on strengthening essential public health functions in support of the achievement of universal health coverage – resolutions in which the Health Assembly prioritized integrated service-delivery models and identified the lack of access to timely emergency care as a cause of extensive and serious public health problems;

Recalling also the mandate of WHO’s Thirteenth General Programme of Work, 2019–2023 to improve integrated service delivery and to serve in particular the most disadvantaged, marginalized and hard-to-reach populations, to ensure that no one is left behind;²

Noting that providing non-discriminatory access to all people in need of timely care in well organized, safe and high-quality emergency care services can contribute to the reduction of health inequalities;

Noting further that in many countries the emergency care system serves as the major health system safety net and the primary point of access to health services, in particular for marginalized populations, which is not an optimal use of health system resources;

¹ Global Health Estimates 2016: deaths by cause, age, sex, by country and by region, 2000–2016. Geneva: World Health Organization; 2018.

² Thirteenth General Programme of Work, 2019–2023 (as contained in document A71/4 and adopted in resolution WHA71.1 (2018)).

Recognizing that the lack of organized emergency care in many countries leads to wide global discrepancies in outcomes across the range of emergency conditions;

Noting that many emergency care interventions are both effective and cost effective, and that integrated emergency care delivery can save lives and maximize impact across the health system;

Concerned that the lack of investment in frontline emergency care is compromising effectiveness, limiting impact and increasing cost in other parts of the health system;

Acknowledging that frontline health workers, nurses in particular, provide care for the acutely ill and injured, often without the benefit of dedicated training in the management of emergency conditions, and with limited possibilities for consultations;

Noting that improving outcomes requires an understanding of the potential and actual utilization of emergency care, and that existing data do not provide adequate support for effective planning and resource allocation for emergency care;

Considering that WHO has a range of guidance that allows policy-makers, planners and administrators to develop action plans that are best suited to their national contexts, along with resources for training, as well as standards for essential emergency care services and resources at each level of the health system,

1. CALLS FOR additional global efforts in the near term in order to strengthen the provision of emergency care as part of universal health coverage so as to ensure the timely and effective delivery of life-saving health care services to those in need;¹

2. URGES Member States:²

(1) to create policies for sustainable funding and effective governance of, and universal access to, safe, high-quality, needs-based emergency care for all, without regard to sociocultural factors, without requirement for payment prior to care, and within a broader health system that provides quality essential care and services and financial risk protection as part of universal health coverage;

(2) as appropriate, to conduct voluntary assessments using the WHO emergency care system assessments tool to identify gaps and context-relevant action priorities;

(3) to work towards, or promote, at appropriate levels of governance, the inclusion of routine prehospital and hospital emergency unit care within health strategies, and within other relevant planning documents, such as emergency response plans and obstetric and surgical plans;

(4) to develop a governance mechanism, as appropriate to their national context, for the coordination of routine prehospital and hospital-based emergency care services, including linkages with other relevant actors for disaster and outbreak preparedness and response, and including the capacity of personnel in other sectors;

(5) to promote more coherent and inclusive approaches to safeguard effective emergency care systems as a pillar of universal health coverage in fragile situations and conflict-affected areas,

¹ See Emergency and trauma care [website]. Geneva: World Health Organization; 2019 (<https://www.who.int/emergencycare/en/>, accessed 20 May 2019).

² And, where applicable, regional economic integration organizations.

ensuring the continuum and provision of essential health services, and public health functions, in line with humanitarian principles;

(6) to promote, as appropriate, according to the level of health care services, from first level and above, the establishment of a dedicated area or unit for emergency services and care with appropriate equipment and capacity for management and diagnosis;

(7) to promote access to timely prehospital care for all, by using informal or formal systems, as resources allow, including by establishing, where they do not exist, toll-free universal access numbers that meet international standards;

(8) to implement key processes and protocols as identified in WHO guidance on emergency care systems, such as triage and checklists,¹ as appropriate;

(9) to provide dedicated training in the management of emergency conditions for all relevant types of health providers, including by developing post-graduate training programmes for doctors and nurses, by training frontline providers in basic emergency care, by integrating dedicated emergency care training into undergraduate nursing and medical curricula, and by establishing certification pathways for prehospital providers, as appropriate to their national context;

(10) to increase awareness and capacity in communities to deal with emergency situations, including through campaigns, and through training of standard practices across educational and occupational settings, adapted to their corresponding target populations, so that they can identify, mitigate and refer potential emergencies;

(11) to implement mechanisms for standardized data collection to characterize the local acute disease burden and identify high-yield mechanisms for improving the coordination, safety and quality of emergency care;

(12) to support efforts to ensure, based on local risks, that prehospital and hospital emergency units have plans in place to protect providers, patients and infrastructure from violence and to protect providers and patients from discrimination; and that they have in place clear protocols for the prevention and management of hazardous exposures;

3. REQUESTS the Director-General:

(1) to enhance WHO's capacity at all levels to provide necessary technical guidance and support for the efforts of Member States and other relevant actors to strengthen emergency care systems, including work to ensure preparedness in all relevant contexts;

(2) to foster multisectoral networks, partnerships and action plans, and to facilitate collaboration among Member States, in support of the effective dissemination and implementation of best practices in emergency care;

(3) to promote equitable and non-discriminatory access to safe, quality emergency care services for all people as part of universal health coverage;

(4) to renew efforts outlined in resolution WHA60.22 to provide support to Member States, upon request, for needs assessments, facility inspection, quality- and safety-improvement

¹ See Emergency and trauma care [website]. Geneva: World Health Organization; 2019 (<https://www.who.int/emergencycare/en/>, accessed 20 May 2019).

programmes, review of legislation, and other aspects of strengthening the provision of emergency care;

(5) to support Member States to expand policy-making, administrative and clinical capacity in the area of emergency care, by the provision of policy options and technical guidance, supported by educational strategies and materials for providers and planners;

(6) to strengthen the evidence base for emergency care by encouraging research on the burden of acute disease and emergency care delivery, and by providing tools, protocols, indicators and other needed standards to support the collection and analysis of data, including on cost-effectiveness;

(7) to facilitate awareness and international and domestic resource mobilization, in line with the Addis Ababa Action Agenda of the Third International Conference on Financing for Development¹ by providing advocacy resources;

(8) to report to the Seventy-fourth World Health Assembly in 2021 on progress in the implementation of this resolution.

(Seventh plenary meeting, 28 May 2019
Committee B, fourth report)

¹ United Nations General Assembly resolution 69/313 (2015).

DECISIONS

WHA72(1) **Composition of the Committee on Credentials**

The Seventy-second World Health Assembly appointed a Committee on Credentials consisting of delegates of the following Member States: Bahrain, Cambodia, Dominican Republic, Eritrea, Indonesia, Liberia, Marshall Islands, Montenegro, Poland, Seychelles, Slovakia, Suriname.

(First plenary meeting, 20 May 2019)

WHA72(2) **Election of officers of the Seventy-second World Health Assembly**

The Seventy-second World Health Assembly elected the following officers:

President: Dr Bounkong Syhavong (Lao People's Democratic Republic)

Vice-Presidents: H.E. Ms Socorro Flores Liera (Mexico)
Mr Abdoulaye Diouf Sarr (Senegal)
Dr Hussain Abdul Rahman Al Rand (United Arab Emirates)
Dr Alisher Shadmanov (Uzbekistan)
Mrs Dechen Wangmo (Bhutan)

(First plenary meeting, 20 May 2019)

WHA72(3) **Election of officers of the main committees**

The Seventy-second World Health Assembly elected the following officers of the main committees:

Committee A: Chairman Dr Silvia Paula Valentim Lutucuta (Angola)
Committee B: Chairman Mr Herbert Barnard (Netherlands)

(First plenary meeting, 20 May 2019)

The main committees subsequently elected the following officers:

Committee A: Vice-Chairmen Dr Yasuhiro Suzuki (Japan)
Dr Mohammad Assai Ardakani (Islamic Republic of Iran)

Rapporteur Ms Laura Bordón (Paraguay)

Committee B: Vice-Chairmen Dr Karen Gordon-Campbell (Guyana)
Mr Abdulla Ameen (Maldives)

Rapporteur Dr Ahmad Jan Naeem (Afghanistan)

(First meetings of Committees A and B,
20 and 22 May 2019, respectively)

WHA72(4) Establishment of the General Committee

The Seventy-second World Health Assembly elected the delegates of the following 17 countries as members of the General Committee: Bahamas, China, Congo, Cuba, Democratic Republic of the Congo, Djibouti, France, Honduras, Mongolia, Myanmar, Niger, Romania, Russian Federation, Somalia, South Africa, United Kingdom of Great Britain and Northern Ireland, United States of America.

(First plenary meeting, 20 May 2019)

WHA72(5) Adoption of the agenda

The Seventy-second World Health Assembly adopted the provisional agenda prepared by the Executive Board at its 144th session, with the deletion of five items and the exclusion of one supplementary item.

(Second plenary meeting, 20 May 2019)

WHA72(6) Verification of credentials

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

(Fifth plenary meeting, 22 May 2019)

WHA72(7) Election of Members entitled to designate a person to serve on the Executive Board

The Seventy-second World Health Assembly, after considering the recommendations of the General Committee, elected the following as Members entitled to designate a person to serve on the Executive Board: Argentina, Austria, Bangladesh, Burkina Faso, Grenada, Guyana, Kenya, Singapore, Tajikistan, Tonga, Tunisia, United Arab Emirates.

(Sixth plenary meeting, 24 May 2019)

WHA72(8) Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan¹

The Seventy-second World Health Assembly, taking note of the report by the Director-General requested in decision WHA71(10) (2018),² decided to request the Director-General:

- (1) to report on progress in the implementation of the recommendations contained in the report by the Director-General, based on field monitoring, to the Seventy-third World Health Assembly;
- (2) to provide support to the Palestinian health services, including through capacity-building programmes and the development of strategic plans for investments in specific treatment and diagnostic capacities locally;
- (3) to ensure sustainable procurement of WHO prequalified vaccines and medicine, and medical equipment, to the occupied Palestinian territory in compliance with international humanitarian law and WHO norms and standards;
- (4) to provide health-related technical assistance to the Syrian population in the occupied Syrian Golan;
- (5) to continue providing the necessary technical assistance in order to meet the health needs of the Palestinian people, including prisoners and detainees, in cooperation with the efforts of the International Committee of the Red Cross, as well as the health needs of handicapped and injured people;
- (6) to support the development of the health system in the occupied Palestinian territory, including east Jerusalem, by: focusing on the development of human resources, in order to localize health services, decreasing referrals and reducing cost; strengthening provision of mental health services; and maintaining strong primary health care with integrated complete appropriate health services;
- (7) to ensure the allocation of human and financial resources in order to achieve these objectives.

(Sixth plenary meeting, 24 May 2019 –
Committee B, first report)

¹ See Annex 9 for the financial and administrative implications for the Secretariat of this decision.

² Document A72/33.

WHA72(9) WHO global strategy on health, environment and climate change: the transformation needed to improve lives and well-being sustainably through healthy environments

The Seventy-second World Health Assembly, having considered the report on health, environment and climate change: draft WHO global strategy on health, environment and climate change – the transformation needed to improve lives and well-being sustainably through healthy environments,¹ decided:

- (1) to note the WHO global strategy on health, environment and climate change;²
- (2) to request the Director-General to report back on progress made in the implementation of the WHO global strategy on health, environment and climate change to the Seventy-fourth World Health Assembly.

(Seventh plenary meeting, 28 May 2019 –
Committee A, third report)

WHA72(10) Plan of action on climate change and health in small island developing States

The Seventy-second World Health Assembly, having considered the draft plan of action on climate change and health in small island developing States,³ decided:

- (1) to note the plan of action on climate change and health in small island developing States;⁴
- (2) to request the Director-General to report back on progress in the implementation of the plan of action on climate change and health in small island developing States to the Seventy-fourth World Health Assembly.

(Seventh plenary meeting, 28 May 2019 –
Committee A, third report)

WHA72(11) Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases⁵

The Seventy-second World Health Assembly, having considered the report on follow-up to the high-level meetings of the United Nations General Assembly on health-related issues: prevention and control of noncommunicable diseases,⁶ describing the outcomes of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, decided:

¹ Document A72/15.

² See Annex 2.

³ See document A72/16.

⁴ See Annex 3.

⁵ See Annex 9 for the financial and administrative implications for the Secretariat of this decision.

⁶ Document A72/19.

- (1) to welcome the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases adopted by the United Nations General Assembly in resolution 73/2 (2018), and to request the Director-General to provide support to Member States in its implementation;
- (2) to confirm the objectives of WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2020 and WHO's comprehensive mental health action plan 2013–2020 as a contribution towards the achievement of Sustainable Development Goal target 3.4 (by 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being) and other noncommunicable disease-related goals and targets, and to extend the period of the action plans to 2030 in order to ensure their alignment with the 2030 Agenda for Sustainable Development;
- (3) to request the Director-General:
 - (a) to propose updates to the appendices of WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2020 and WHO's comprehensive mental health action plan 2013–2020, as appropriate, in consultation with Member States and taking into account the views of other stakeholders,¹ ensuring that the action plans remain based on scientific evidence for the achievement of previous commitments for the prevention and control of noncommunicable diseases, including Sustainable Development Goal target 3.4 (by 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being) and other related goals and targets;
 - (b) building on the work already under way, to prepare and update, as appropriate, a menu of policy options and cost-effective interventions to support Member States in implementing the commitments included in the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases (2018) to promote mental health and well-being, for consideration by the Seventy-third World Health Assembly in 2020, through the Executive Board;
 - (c) building on the work already under way, to prepare a menu of policy options and cost-effective interventions to provide support to Member States in implementing the commitments included in the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases (2018) to reduce the number of premature deaths from noncommunicable diseases attributed to air pollution, while recognizing the importance of addressing all environmental determinants, for consideration by the Seventy-third World Health Assembly in 2020, through the Executive Board;
 - (d) to report to the Seventy-third World Health Assembly in 2020, through the Executive Board, on the implementation of WHO's global strategy to reduce the harmful use of alcohol during the first decade since its endorsement, and the way forward;
 - (e) to consolidate reporting on the progress achieved in the prevention and control of noncommunicable diseases and the promotion of mental health with an annual report to be submitted to the Health Assembly through the Executive Board, from 2021 to 2031,

¹ In accordance with WHO's Framework of Engagement with Non-State Actors.

annexing reports on implementation of relevant resolutions, action plans and strategies,^{1,2} in line with existing reporting mandates and timelines;

(f) to provide further concrete guidance to Member States in order to strengthen health literacy through education programmes and population-wide targeted and mass- and social-media campaigns to reduce the impact of all risk factors and determinants of noncommunicable diseases, to be presented to the Seventy-fourth World Health Assembly in 2021;

(g) to present, in the consolidated report to the Seventy-fourth World Health Assembly in 2021, based on a review of international experiences, an analysis of successful approaches to multisectoral action for the prevention and control of noncommunicable diseases, including those that address the social, economic and environmental determinants of such diseases;

(h) to collect and share best practices for the prevention of overweight and obesity, and in particular to analyse how food procurement in schools and other relevant institutions can be made supportive of healthy diets and lifestyles in order to address the epidemic of childhood overweight and obesity and reduce malnutrition in all its forms, for inclusion in the consolidated report to be presented in 2021 in line with paragraph 3(e);

(i) to provide the necessary technical support to Member States in integrating the prevention and control of noncommunicable diseases and the promotion of mental health into primary health care services, and in improving noncommunicable disease surveillance;

(j) to make available adequate financial and human resources to respond to the demand from Member States for technical support in order to strengthen their national efforts for the prevention and control of noncommunicable diseases, including by identifying innovative voluntary funding mechanisms, such as a multi-donor trust fund, building on ongoing relevant work.

(Seventh plenary meeting, 28 May 2019 –
Committee A, fourth report)

¹ Including those requested in: resolution WHA53.17 (2000) on prevention and control of noncommunicable diseases; resolution WHA57.17 (2004) on the global strategy on diet, physical activity and health; resolution WHA63.13 (2010) on the global strategy to reduce the harmful use of alcohol; resolution WHA65.6 (2012) on the comprehensive implementation plan on maternal, infant and young child nutrition; resolution WHA66.8 (2013) on the comprehensive mental health action plan 2013–2020; resolution WHA66.10 (2013) on the follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases; resolution WHA68.19 (2015) on the outcome of the Second International Conference on Nutrition; resolution WHA70.12 (2017) on cancer prevention and control in the context of an integrated approach; decision WHA70(17) (2017) on the global action plan on the public health response to dementia; decision WHA70(19) (2017) on the report of the Commission on Ending Childhood Obesity: implementation plan; resolution WHA71.6 (2018) on WHO's global action plan on physical activity 2018–2030; and resolution WHA71.9 (2018) on infant and young child feeding.

² Including reports on the findings of a mid-point and final evaluation in accordance with paragraph 60 of WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2020, and on the findings of a preliminary and final evaluation in accordance with paragraph 19 of the terms of reference of the WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases.

WHA72(12) Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits¹

The Seventy-second World Health Assembly, having considered the reports on implementation of decision WHA71(11) (2018),² and taking note of the Pandemic Influenza Preparedness (PIP) Framework Advisory Group's recommendations to the Director-General,³ decided:

- (1) to request the Director-General:
 - (a) to work with the Global Influenza Surveillance and Response System (GISRS) and other partners, such as Other Authorized Laboratories and relevant institutions, to collect, analyse, and present data on influenza virus sharing in a way that enables a deeper understanding of the challenges, opportunities and implications for public health associated with virus sharing under the GISRS, including by identifying: specific instances where influenza virus sharing has been hindered; and how such instances may be mitigated;
 - (b) to prepare a report, with inputs from Member States⁴ and stakeholders, as appropriate, on the treatment of influenza virus sharing and the public health considerations thereof by existing relevant legislation and regulatory measures, including those implementing the Nagoya Protocol, in consultation with the Secretariat of the Convention on Biological Diversity as appropriate;
 - (c) to provide more information on the functioning, usefulness and limitations of the prototype search engine;
 - (d) to explore, including through soliciting input from Member States, possible next steps in raising awareness of the PIP Framework among relevant databases and initiatives, data providers and data users, and in promoting the acknowledgment of data providers and collaboration between data providers and data users;
 - (e) to continue providing information on new challenges posed and opportunities provided by new technologies in the context of the PIP Framework for the sharing of influenza viruses and access to vaccines and other benefits and possible approaches to them;
- (2) to revise Footnote 1 in the Standard Material Transfer Agreement 2 (SMTA2), in Annex 2 to the PIP Framework, as set out in Annex 4, B with effect from the closure of the Seventy-second World Health Assembly;
- (3) to further request the Director-General to report on implementation of the foregoing to the Seventy-third World Health Assembly in 2020, through the Executive Board at its 146th session.

(Seventh plenary meeting, 28 May 2019 –
Committee A, fourth report)

¹ See Annex 9 for the financial and administrative implications for the Secretariat of this decision.

² Documents A72/21 and A72/21 Add.1.

³ See Annex 4, A.

⁴ And, where applicable, regional economic integration organizations.

WHA72(13) The public health implications of implementation of the Nagoya Protocol¹

The Seventy-second World Health Assembly, recalling the Convention on Biological Diversity and its objectives and principle, and the Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization to the Convention on Biological Diversity and its objective; reaffirming the WHO Constitution and the International Health Regulations (2005); and having considered the report by the Director-General on the public health implications of implementation of the Nagoya Protocol,² decided to request the Director-General, in order to broaden engagement with Member States, the secretariat of the Convention on Biological Diversity, relevant international organizations and relevant stakeholders:

- (1) to provide information on current pathogen-sharing practices and arrangements, the implementation of access and benefit-sharing measures, as well as the potential public health outcomes and other implications; and
- (2) to provide a report to the Seventy-fourth World Health Assembly, through the Executive Board at its 148th session, as well as an interim report to the Executive Board at its 146th session.

(Seventh plenary meeting, 28 May 2019 –
Committee A, sixth report)

WHA72(14) Promoting the health of refugees and migrants

The Seventy-second World Health Assembly, having considered the report on promoting the health of refugees and migrants³ decided:

- (1) to take note of the WHO global action plan on promoting the health of refugees and migrants, 2019–2023;⁴
- (2) to request the Director-General to report back on progress in the implementation of the WHO global action plan on promoting the health of refugees and migrants, 2019–2023, including relevant information provided by Member States on a voluntary basis and United Nations agencies as appropriate, to the Seventy-fourth and Seventy-sixth World Health Assemblies.

(Seventh plenary meeting, 28 May 2019 –
Committee A, sixth report)

WHA72(15) Report of the External Auditor

The Seventy-second World Health Assembly, having considered the report of the External Auditor to the Health Assembly;⁵ and having noted the report of the Programme, Budget and

¹ See Annex 9 for the financial and administrative implications for the Secretariat of this decision.

² Document A72/32.

³ Document A72/25 Rev.1.

⁴ See Annex 5.

⁵ Document A72/39.

Administration Committee of the Executive Board to the Seventy-second World Health Assembly,¹ decided to accept the report of the External Auditor to the Health Assembly.

(Seventh plenary meeting, 28 May 2019 –
Committee B, second report)

WHA72(16) WHO programmatic and financial reports for 2018–2019, including audited financial statements for 2018

The Seventy-second World Health Assembly, having considered the WHO Results Report for the Programme budget 2018–2019: mid-term review² and the audited financial statements for 2018;³ and having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-second World Health Assembly,⁴ decided to accept the WHO Results Report for the Programme budget 2018–2019: mid-term review and the audited financial statements for 2018.

(Seventh plenary meeting, 28 May 2019 –
Committee B, second report)

WHA72(17) Human resources: annual report

The Seventy-second World Health Assembly, having considered paragraph 27 of the report by the Secretariat, Human resources: annual report;⁵ and having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-second World Health Assembly,⁶ decided to amend paragraph II (3) of the contract of the Director-General, as set out in Annex 6, in order to allow for the retroactive participation of the Director-General in the United Nations Joint Staff Pension Fund as of 1 July 2017.

(Seventh plenary meeting, 28 May 2019 –
Committee B, third report)

WHA72(18) Appointment of representatives to the WHO Staff Pension Committee

The Seventy-second World Health Assembly appointed Dr Gerardo Lubin Burgos Bernal of the delegation of Colombia as a member of the WHO Staff Pension Committee for a three-year term until the closure of the Seventy-fifth World Health Assembly in May 2022.

¹ Document A72/67.

² Document A72/35.

³ Documents A72/36 and A72/INF./5.

⁴ Document A72/62.

⁵ Document A72/43.

⁶ Document A72/65.

The Health Assembly appointed Dr Arthur Williams of the delegation of Sierra Leone as an alternate member of the WHO Staff Pension Committee for a three-year term until the closure of the Seventy-fifth World Health Assembly in May 2022.

(Seventh plenary meeting, 28 May 2019 –
Committee B, third report)

WHA72(19) 2020: International Year of the Nurse and the Midwife¹

The Seventy-second World Health Assembly, having considered document A72/54 Rev.1, decided to designate 2020 as the International Year of the Nurse and the Midwife.

(Seventh plenary meeting, 28 May 2019 –
Committee B, third report)

WHA72(20) World Chagas Disease Day¹

The Seventy-second World Health Assembly, having considered document A72/55 Rev.1, decided to establish World Chagas Disease Day, to be celebrated on 14 April.

(Seventh plenary meeting, 28 May 2019 –
Committee B, third report)

WHA72(21) WHO reform: amendments to the Rules of Procedure of the World Health Assembly (replacing or supplementing gender-specific language)¹

The Seventy-second World Health Assembly, having considered the report by the Director-General on WHO reform,² decided:

(1) to amend its Rules of Procedure in line with the examples set out in the Annex to document A72/50 in order to replace or supplement gender-specific language so as to indicate both feminine and masculine forms in the English language only and to follow United Nations' practice for the other five official and working languages of WHO's governing bodies, in accordance with Rule 119 of the Rules of Procedure of the World Health Assembly;³

(2) that the amendments shall come into effect at the moment when the Director-General renumbers the Rules of Procedure of the World Health Assembly in accordance with decision WHA72(23) (2019).

(Seventh plenary meeting, 28 May 2019 –
Committee B, third report)

¹ See Annex 9 for the financial and administrative implications for the Secretariat of this decision.

² Document A72/50.

³ See Annex 7.

WHA72(22) WHO reform: amendments to the Rules of Procedure of the World Health Assembly (report of the Executive Board Chairperson on the outcome of the informal consultation on governance reform)¹

The Seventy-second World Health Assembly, having considered the report by the Director-General on the report of the Executive Board Chairperson on the outcome of the informal consultation on governance reform,² decided:

- (1) to amend Rules 5, 11, and 12 of the Rules of Procedure of the World Health Assembly as set out in Annex 8, in accordance with Rule 119 of the Rules of Procedure of the World Health Assembly, with effect from the closure of its Seventy-second session; and to recommend that the explanatory memorandum referred to in the third paragraph of Rule 5 of the Rules of Procedure of the World Health Assembly, as amended, be limited to 500 words;
- (2) to amend Rule 48 of the Rules of Procedure of the World Health Assembly as set out in Annex 8, in accordance with Rule 119 of the Rules of Procedure of the World Health Assembly, with effect from the closure of its Seventy-second session;
- (3) to amend the definitions at the beginning of the Rules of Procedure of the World Health Assembly, Rules 3, 14, 19, 22, the heading between Rule 43 and Rule 44, and Rule 47 of the Rules of Procedure of the World Health Assembly as set out in Annex 8, in accordance with Rule 119 of the Rules of Procedure of the World Health Assembly, with effect from the closure of its Seventy-second session;
- (4) that resolutions and decisions should provide for clear reporting requirements, including reporting cycles of up to six years, with biennial reports, unless otherwise advised by the Director-General.

(Seventh plenary meeting, 28 May 2019 –
Committee B, third report)

WHA72(23) WHO reform: amendments to the Rules of Procedure of the World Health Assembly (dealing with interpretational ambiguities and gaps in the process for the inclusion of additional, supplementary and urgent agenda items, and addressing other ambiguities, gaps and shortcomings in the Rules of Procedure of the World Health Assembly)

The Seventy-second World Health Assembly, having considered the report by the Director-General on WHO reform: governance,³ decided:

- (1) to adopt the amendments to the Rules of Procedure of the World Health Assembly, as set out in Annex 8, in accordance with Rule 119 of the Rules of Procedure of the World Health Assembly, with effect from the closure of that session of the Health Assembly;

¹ See Annex 9 for the financial and administrative implications for the Secretariat of this decision.

² Document A72/51.

³ Document A72/52.

(2) to request the Director-General to renumber the Rules of Procedure of the World Health Assembly, at an appropriate time, taking into account the amendments adopted through this decision.

(Seventh plenary meeting, 28 May 2019 –
Committee B, third report)

WHA72(24) Selection of the country in which the Seventy-third World Health Assembly would be held

The Seventy-second World Health Assembly, in accordance with Article 14 of the Constitution, decided that the Seventy-third World Health Assembly would be held in Switzerland.

(Seventh plenary meeting, 28 May 2019)

ANNEXES

ANNEX 1

Declaration of Astana¹

We, Heads of State and Government, ministers and representatives of States and Governments,² participating in the Global Conference on Primary Health Care: From Alma-Ata towards Universal Health Coverage and the Sustainable Development Goals, meeting in Astana on 25 and 26 October 2018, reaffirming the commitments expressed in the ambitious and visionary Declaration of Alma-Ata of 1978 and the 2030 Agenda for Sustainable Development, in pursuit of Health for All, hereby make the following Declaration.

We envision

Governments and societies that prioritize, promote and protect people's health and well-being, at both population and individual levels, through strong health systems;

Primary health care and health services that are high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed;

Enabling and health-conducive environments in which individuals and communities are empowered and engaged in maintaining and enhancing their health and well-being;

Partners and stakeholders aligned in providing effective support to national health policies, strategies and plans.

I

We strongly affirm our commitment to the fundamental right of every human being to the enjoyment of the highest attainable standard of health without distinction of any kind. Convening on the fortieth anniversary of the Declaration of Alma-Ata, we reaffirm our commitment to all its values and principles, in particular to justice and solidarity, and we underline the importance of health for peace, security and socioeconomic development, and their interdependence.

II

We are convinced that strengthening primary health care (PHC) is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being, and that PHC is a cornerstone of a sustainable health system for universal health coverage (UHC) and health-related Sustainable Development Goals. We welcome the convening in 2019 of the United Nations General Assembly high-level meeting on UHC, to which this Declaration will contribute. We will each

¹ See resolution WHA72.2; see also Declaration of Astana. Geneva: World Health Organization/United Nations Children's Fund; 2018 (<https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf>).

² As well as representatives of regional economic integration organizations.

pursue our paths to achieving UHC so that all people have equitable access to the quality and effective health care they need, ensuring that the use of these services does not expose them to financial hardship.

III

We acknowledge that in spite of remarkable progress over the last 40 years, people in all parts of the world still have unaddressed health needs. Remaining healthy is challenging for many people, particularly the poor and people in vulnerable situations. We find it ethically, politically, socially and economically unacceptable that inequity in health and disparities in health outcomes persist.

We will continue to address the growing burden of noncommunicable diseases, which lead to poor health and premature deaths due to tobacco use, the harmful use of alcohol, unhealthy lifestyles and behaviours, and insufficient physical activity and unhealthy diets. Unless we act immediately, we will continue to lose lives prematurely because of wars, violence, epidemics, natural disasters, the health impacts of climate change and extreme weather events and other environmental factors. We must not lose opportunities to halt disease outbreaks and global health threats such as antimicrobial resistance that spread beyond countries' boundaries.

Promotive, preventive, curative, rehabilitative services and palliative care must be accessible to all. We must save millions of people from poverty, particularly extreme poverty, caused by disproportionate out-of-pocket spending on health. We can no longer underemphasize the crucial importance of health promotion and disease prevention, nor tolerate fragmented, unsafe or poor-quality care. We must address the shortage and uneven distribution of health workers. We must act on the growing costs of health care and medicines and vaccines. We cannot afford waste in health care spending due to inefficiency.

We commit to:

IV

Make bold political choices for health across all sectors

We reaffirm the primary role and responsibility of Governments at all levels in promoting and protecting the right of everyone to the enjoyment of the highest attainable standard of health. We will promote multisectoral action and UHC, engaging relevant stakeholders and empowering local communities to strengthen PHC. We will address economic, social and environmental determinants of health and aim to reduce risk factors by mainstreaming a Health in All Policies approach. We will involve more stakeholders in the achievement of Health for All, leaving no one behind, while addressing and managing conflicts of interest, promoting transparency and implementing participatory governance. We will strive to avoid or mitigate conflicts that undermine health systems and roll back health gains. We must use coherent and inclusive approaches to expand PHC as a pillar of UHC in emergencies, ensuring the continuum of care and the provision of essential health services in line with humanitarian principles. We will appropriately provide and allocate human and other resources to strengthen PHC. We applaud the leadership and example of Governments who have demonstrated strong support for PHC.

V

Build sustainable primary health care

PHC will be implemented in accordance with national legislation, contexts and priorities. We will strengthen health systems by investing in PHC. We will enhance capacity and infrastructure for primary care – the first contact with health services – prioritizing essential public health functions. We will prioritize disease prevention and health promotion and will aim to meet all people’s health needs across the life course through comprehensive preventive, promotive, curative, rehabilitative services and palliative care. PHC will provide a comprehensive range of services and care, including but not limited to vaccination; screenings; prevention, control and management of noncommunicable and communicable diseases; care and services that promote, maintain and improve maternal, newborn, child and adolescent health; and mental health and sexual and reproductive health¹. PHC will also be accessible, equitable, safe, of high quality, comprehensive, efficient, acceptable, available and affordable, and will deliver continuous, integrated services that are people-centred and gender-sensitive. We will strive to avoid fragmentation and ensure a functional referral system between primary and other levels of care. We will benefit from sustainable PHC that enhances health systems’ resilience to prevent, detect and respond to infectious diseases and outbreaks.

The success of primary health care will be driven by:

Knowledge and capacity-building. We will apply knowledge, including scientific as well as traditional knowledge, to strengthen PHC, improve health outcomes and ensure access for all people to the right care at the right time and at the most appropriate level of care, respecting their rights, needs, dignity and autonomy. We will continue to research and share knowledge and experience, build capacity and improve the delivery of health services and care.

Human resources for health. We will create decent work and appropriate compensation for health professionals and other health personnel working at the primary health care level to respond effectively to people’s health needs in a multidisciplinary context. We will continue to invest in the education, training, recruitment, development, motivation and retention of the PHC workforce, with an appropriate skill mix. We will strive for the retention and availability of the PHC workforce in rural, remote and less developed areas. We assert that the international migration of health personnel should not undermine countries’, particularly developing countries’, ability to meet the health needs of their populations.

Technology. We support broadening and extending access to a range of health care services through the use of high- quality, safe, effective and affordable medicines, including, as appropriate, traditional medicines, vaccines, diagnostics and other technologies. We will promote their accessibility and their rational and safe use and the protection of personal data. Through advances in information systems, we will be better able to collect appropriately disaggregated, high-quality data and to improve information continuity, disease surveillance, transparency, accountability and monitoring of health system performance. We will use a variety of technologies to improve access to health care, enrich health service delivery, improve the quality of service and patient safety, and increase the efficiency and coordination of care. Through digital and other technologies, we will enable individuals and

¹ In joining consensus, the delegation of the United States of America wishes to draw attention to objective 8.25 of the Programme of Action of the Report of the International Conference on Population and Development, which states “in no case should abortion be promoted as a method of family planning”.

communities to identify their health needs, participate in the planning and delivery of services and play an active role in maintaining their own health and well-being.

Financing. We call on all countries to continue to invest in PHC to improve health outcomes. We will address the inefficiencies and inequities that expose people to financial hardship resulting from their use of health services by ensuring better allocation of resources for health, adequate financing of primary health care and appropriate reimbursement systems in order to improve access and achieve better health outcomes. We will work towards the financial sustainability, efficiency and resilience of national health systems, appropriately allocating resources to PHC based on national context. We will leave no one behind, including those in fragile situations and conflict-affected areas, by providing access to quality PHC services across the continuum of care.

VI

Empower individuals and communities

We support the involvement of individuals, families, communities and civil society through their participation in the development and implementation of policies and plans that have an impact on health. We will promote health literacy and work to satisfy the expectations of individuals and communities for reliable information about health. We will support people in acquiring the knowledge, skills and resources needed to maintain their health or the health of those for whom they care, guided by health professionals. We will protect and promote solidarity, ethics and human rights. We will increase community ownership and contribute to the accountability of the public and private sectors for more people to live healthier lives in enabling and health-conducive environments.

VII

Align stakeholder support to national policies, strategies and plans

We call on all stakeholders – health professionals, academia, patients, civil society, local and international partners, agencies and funds, the private sector, faith-based organizations and others – to align with national policies, strategies and plans across all sectors, including through people-centred, gender-sensitive approaches, and to take joint actions to build stronger and sustainable PHC towards achieving UHC. Stakeholder support can assist countries to direct sufficient human, technological, financial and information resources to PHC. In implementing this Declaration, countries and stakeholders will work together in a spirit of partnership and effective development cooperation, sharing knowledge and good practices while fully respecting national sovereignty and human rights.

- We will act on this Declaration in solidarity and coordination between Governments, the World Health Organization, the United Nations Children's Fund and all other stakeholders.
 - All people, countries and organizations are encouraged to support this movement.
 - Countries will periodically review the implementation of this Declaration, in cooperation with stakeholders.
 - Together we can and will achieve health and well-being for all, leaving no one behind.
-

ANNEX 2

WHO global strategy on health, environment and climate change: the transformation needed to improve lives and well-being sustainably through healthy environments¹

[A72/15 – 18 April 2019]

[Paragraphs 1–2 described the background to the strategy, including the process of its development.]

SCOPE

3. This strategy aims to provide a vision and way forward on how the world and its health community need to respond to environmental health risks and challenges until 2030, and to ensure safe, enabling and equitable environments for health by transforming our way of living, working, producing, consuming and governing.

4. Environmental risks to health, in the framework of this strategy, are defined as all the environmental physical, chemical, biological and work-related factors external to a person, and all related behaviours. It focuses especially on the part of the environment that can reasonably be modified.

THE CHALLENGE

5. The current situation and the challenges ahead call for a transformation in the way we manage our environment with respect to health and well-being. Current approaches have laid the foundations, but they have not proven sufficient for sustainably and efficiently reducing environmental risks to health and building health-supportive and enabling environments – hence the call for a new strategy on health, environment and climate change.

6. Known avoidable environmental risks cause about one quarter of all deaths and disease burden worldwide, amounting to at least a steady 13 million deaths each year.² A healthy environment is vital for human health and development. Air pollution – one of the largest risks to health – alone causes seven million preventable deaths per year, with more than 90% of people breathing polluted air and almost 3000 million people still depending on polluting fuels such as solid fuels or kerosene for lighting, cooking and heating.³ More than half the world's population is still exposed to unsafely managed water,

¹ See decision WHA72(9).

² Based on the following assessments: Prüss-Üstün A, Corvalán C. Preventing disease through healthy environments: towards an estimate of the environmental burden of disease. Geneva: World Health Organization; 2006, and Prüss-Üstün A, Wolf J, Cornavalán CF, Bos R, Neira MP. Preventing disease through healthy environments: a global assessment of the burden of disease from environmental risks. Geneva: World Health Organization; 2016 (<https://apps.who.int/iris/handle/10665/43457> and https://www.who.int/quantifying_ehimpacts/publications/preventing-disease/en/, both accessed 26 March 2019).

³ WHO news release. 9 out of 10 people worldwide breathe polluted air, but more countries are taking action. Geneva: World Health Organization; 2018 (<https://www.who.int/news-room/detail/02-05-2018-9-out-of-10-people-worldwide-breathe-polluted-air-but-more-countries-are-taking-action>, accessed 26 March 2019).

inadequate sanitation and poor hygiene, resulting in more than 800 000 preventable deaths each year.¹ A large fraction of malaria cases and other vector-borne diseases is closely linked to the management and manipulation of the environment, such as drainage, irrigation schemes or design of dams. More than one million workers die each year because their workplace is unsafe, and more than one million people die from exposure to chemicals.

7. Climate change increasingly affects people's health and well-being, as do other global environmental changes such as loss of biodiversity. Climate change is increasing the frequency and intensity of heatwaves, droughts, extreme rainfall and severe cyclones in many areas, and modifying the transmission of food-borne, water-borne and zoonotic infectious diseases, resulting in large impacts on health. Those who are vulnerable or in vulnerable situations, including people living on small islands, in the Arctic, in water-stressed and low-lying areas, and those in the least developed countries and regions, are at higher risk. Wider-ranging potential consequences include scarcity of water and forced migration with the political tensions these involve. These phenomena form part of a wide pattern of consequences of global environmental change, for example the rapid loss of: biodiversity and ecosystem stability, which undermine food and water security; protection from extreme weather; and the discovery of new medicines.

8. Despite substantive efforts to reduce environmental risks to health, traditional public health risks (for instance, unsafe drinking-water and poor sanitation) persist, which challenge health equity. Important advances have been made to protect people from known environmental risks by setting norms and guidelines, implementing solutions, including regulatory action, and monitoring efforts. They provide the basis for environmental health protection and need to be scaled up. Nonetheless, uneven development has left behind large parts of the global population, who still lack access to basic environmental services, such as sanitation, safe drinking-water, clean air, and reliable food sources. Moreover, there are gaps in institutional capacities for health protection through legislation, management of chemical and other hazards, and emergency response. The effects of human actions on the environment also raise ethical and human rights issues, as they will be felt by future generations and will continue to disproportionately affect populations in situations of vulnerability, across all ages and gender, and among those socioeconomic groups who have often contributed least to environmental changes.

9. New environmental, climatic and health issues are emerging and require rapid identification and response. Recent examples include the management of electronic waste, some nanoparticles, microplastics and endocrine-disrupting chemicals. The world is changing rapidly, with an increased pace of technological development, new organization of work (such as digital platforms, subcontracting and teleworking), increased migration, climate change and increasing water scarcity; it needs to be able to identify and respond to such changes and emerging issues in a timely manner.

10. Stakeholders, health authorities and communities should be more active in shaping the energy transition, guiding urbanization and ameliorating the negative effects of other major development trends, so as to protect and promote health. Large-scale changes that societies are continuing to experience include: increasing demands for energy, transport and technological innovation, with an expanded range of options to meet such demands; urbanization, with more than half the world's population now living in cities (the proportion will increase to almost 70% by 2050)²; and increased mobility of people, goods and services. Health is rarely central to decisions affecting these trends, resulting in missed opportunities for health protection and promotion. Poorly planned and managed urban settings with unsustainable

¹ WHO. Global Health Observatory: the data repository. Geneva: World Health Organization; 2018 (data for 2016 retrieved 11 September 2018 from <http://apps.who.int/gho/data/view.main.INADEQUATEWSHV?lang=en/>).

² United Nations. World urbanization prospects: the 2018 revision – key facts. New York: United Nations; 2018 (<https://population.un.org/wup/Publications/Files/WUP2018-KeyFacts.pdf>, accessed, 26 March 2019).

transport systems and a lack of access to public and green areas increase air pollution, noise and heat islands, reduce opportunities for physical activity and access to decent jobs and education, and have a negative impact on community life and people's physical and mental health. Because of the close relation between air pollution and climate change, failure to tackle air pollution and to mitigate climate change together result in a lost opportunity to gain the health, economic and environmental multiple benefits that would derive from more efficient transport and energy systems, a low-carbon economy, and healthier food systems with less impact on the environment. New approaches are needed that consider the consequences of actions in their entirety, taking a longer-term and equity perspective. Finally, a diverse set of individual groups and stakeholders should be engaged in developing evidence-based approaches in which public health interest is paramount.

11. The sustainability of health systems is put at risk if the upstream determinants¹ of disease are not seriously tackled. About 10% of global gross domestic product is being spent on health care, but very little goes to prevention.² The recurrent and high rates of diarrhoeal diseases, respiratory infections and particularly noncommunicable diseases caused by the environment weigh heavily on health services and national household budgets. Financial and human resources allocated to health promotion and primary prevention remain inadequate to reduce the substantial burden of disease caused by environmental risks to health. Failure to reflect costs of all consequences of policies, technologies and products in pricing structures will merely continue to transfer costs to the health sector and to citizens.

12. Approaches that focus on treatment of individual diseases rather than reducing the adverse impact of determinants of health will be insufficient to tackle modern environmental health challenges. Single-determinant approaches are unlikely to achieve expected improvements in health equity and well-being, given the complex interaction of factors at the level of borders between countries, society and the individual. Approaches that are more integrated are required to address the upstream determinants of disease, which are often defined by policies in key sectors other than health. Failing to address the upstream determinants of disease and over-reliance on medicines and insecticides are even leading to increasing problems such as antimicrobial and insecticide resistance, with potentially substantial implications for public health.

13. Knowledge gaps continue to prevent efficient implementation of health-protective strategies, and more evidence-based and efficient communication is needed. Evidence is still incomplete or lacking on certain risks to health, such as climate change, electronic waste and numerous chemicals or their mixtures. The impact on health of employment conditions and work-related risks, such as chemicals, workplace hazards, sedentary work, long working hours, shift work, and labour migration, needs to be better assessed. Equally, more evidence is needed on efficient solutions and strategies and their financial costs, as well as on their effective implementation. Increasingly, such evidence and public health information is communicated through new platforms: these need to be used to their full potential.

14. Current governance mechanisms, including those at the local level, are failing to deal effectively with the cross-cutting nature of environmental health issues. As policies continue to be set without recognition of the impacts that they can have on health and health systems, partly because overarching governance mechanisms are not in place, their overall benefit will be inaccurately represented.

15. The 2030 Agenda for Sustainable Development calls for a new approach to health, environment and equity. By interlinking socioeconomic development with environmental protection, health and well-

¹ In this context, upstream determinants refer to policies or activities directly leading to increased environmental risks to health. Examples include choices in energy generation, agricultural practices, industrial production or business and land use planning leading to increased emissions, harmful exposures or greater vulnerability, fostering unhealthy behaviours, or accelerating climate change.

² Primary prevention aims to prevent disease or injury before it even occurs.

being, it provides overall support for tackling determinants of health as relevant policies are being defined or key choices are being made, in a preventive and sustainable way, rather than repeatedly dealing with adverse impacts and inequalities. The commitment to sustainable patterns of consumption and production and tackling misuse of natural resources and large-scale generation of waste should allow more sustainable economic activities to be carried out and progress to be made on global, cross-border goods for health, such as clean air and a stable climate.

THE VISION

16. The vision of this WHO global strategy is: a world in which sustainable development has eliminated the almost one quarter of the disease burden caused by unhealthy environments, through health protection and promotion, good public health standards, preventive action in relevant sectors and healthy life choices, and which manages environmental risks to health. Key sectors fully integrate health into their decision-making process and maximize societal welfare.

STRATEGIC OBJECTIVES FOR THE TRANSFORMATION NEEDED

17. To address the challenges in health, environment and climate change, governments, society and individuals will all need to continue to rethink the way we live, work, produce, consume and govern. This transformation requires focusing action on upstream determinants of health, the environment and determinants of climate change in an integrated and mainstreamed approach across all sectors, using a public health framework enabled and supported by adequate governance mechanisms and high-level political will, tailored to the national circumstances. The health sector needs to play a new role to drive this transformation, using a sustainable and equitable approach, and socially-just transition.

Strategic objective 1. Primary prevention: to scale up action on health determinants for health protection and improvement in the 2030 Agenda for Sustainable Development

Effective and equitable action will be put in place on the drivers of environmental risks to health.

18. The 2030 Agenda for Sustainable Development calls for tackling environmental risks at their root, that is, through a shift towards primary preventive actions and the promotion of healthy choices. Reducing the 13 million deaths resulting from environmental risks each year requires efficient scale-up of primary preventive action involving all key stakeholders, across all sectors through the following activities.

- (i) **Engagement for massively expanded primary prevention.** An expansion of primary prevention requires a substantial and sustained investment of resources towards addressing major risks to health and changing health behaviours, to create safe and healthy environments and improve people's lives today and in the future. Resources for intersectoral action can be funded by pricing, tax and subsidy reforms that reflect the true costs to society of products, technologies and policies.
- (ii) **Integration of action on primary prevention in disease programmes.** Integration of preventive environmental health action into universal health coverage as a core component, for instance through strategies and programmes for specific diseases (noncommunicable and communicable) and risks (antimicrobial resistance, for example), is essential. According to the

global strategy to prevent noncommunicable diseases,¹ healthy environments, such as clean air, healthy and safe work environments, and chemical safety are key elements in noncommunicable disease prevention, and relevant action is being called for. Adoption of a One Health approach, a holistic, cross-sectoral and multidisciplinary approach, is to be sought where appropriate, for example to address antimicrobial resistance.

Strategic objective 2. Cross-sectoral action: to act on determinants of health in all policies and in all sectors

Policies across sectors will systematically consider health perspectives and evidence, and gain the health co-benefits of environmental protection. An example is ensuring healthy energy and transport transitions.

19. Responsibility for, and tools to tackle, many environmental determinants of health lie outside the direct control of individuals or the health sector alone (see Fig. 1). Substantial transitions in energy, transport and other major systems are under way, which should lead to profound impacts on population health. Therefore, a wider societal, intersectoral, more holistic and population-based public health approach is needed. Examples of good practice are available, but such integrated approaches are not applied universally and are seldom directed to upstream environmental and social determinants of health.

(i) **Systematic consideration of health in the development of health-relevant policies beyond the health sector.** Decisions taken on the drivers of health risks should have the attainment and protection of good health as an explicit aim in key sectors such as energy, transport, housing, labour, industry, food systems² and agriculture, water and sanitation, and urban planning. Such a Health in All Policies approach includes community engagement, coverage of health in environmental and labour regulations and safeguards, and assessment of the health impact of development projects and policies that tackle several environmental health issues in a single setting, community or system.

(ii) **Gaining the health co-benefits of more sustainable policy choices.** The harms and benefits to health of policy actions need to be comprehensively evaluated, alongside the financial and environmental implications. Much greater benefits for health could be achieved through seeking health co-benefits and taking health into account at the outset when defining policies.

¹ United Nations General Assembly. Resolution 73/2. Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases. Time to deliver: accelerating our response to address non-communicable diseases for the health and well-being of present and future generations. 2018 (http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/73/2, accessed 26 March 2019).

² Food safety is covered in the WHO global strategy for food safety: safer food for better health. Geneva: World Health Organization; 2002 (<https://apps.who.int/iris/bitstream/handle/10665/42559/9241545747.pdf>, accessed 26 March 2019).

Fig. 1. Key sectors (non-exhaustive) with relevance to health, environment and climate change



Strategic objective 3. Strengthened health sector: to strengthen health sector leadership, governance and coordination roles

The health sector will play leadership and coordination roles, working together with other sectors with relevance to health, environment and climate change to improve lives.

20. The health sector is directly concerned – as it is compelled to treat acute and chronic disease due to environmental risks, and treatment often needs to be repeated, given that people generally remain in the same exposures once treated. To reduce disease and related costs, the health sector (and other actors responsible for health and environment) needs to be equipped and strengthened to assume its obligations in shaping a healthy and sustainable future. Incremental changes to deal with individual environmental risks are not sufficient. Strengthened capacity of health ministries and other relevant parts of the health workforce is the key to: engaging other sectors of government through leadership, partnership, advocacy and mediation to achieve improved health outcomes; building their institutional capacity and skills to implement a Health in All Policies approach; and providing evidence on the determinants of health and inequity, and on effective responses and solutions. This approach would in turn avoid current or future economic costs caused by treatment of environment-related diseases and their consequences, allowing reinvestment in health and sustainable development.

- (i) **Developing the capacity of the health sector to engage in policies with other sectors.** Staff in the health sector need skills to engage in intersectoral dialogue and in the monitoring of investments and their consequences in other areas of the economy, as well as overall economic strategies and trade, and in the communication of the findings. Increased capacity and capabilities allow the promotion of mutually beneficial measures that simultaneously protect health and the environment. National health ministries – through leadership and intersectoral governance, evidence-based advocacy, operational programmes, and surveillance and monitoring – can drive progress in tackling environmental, social and climatic risks, to obtain short- and long-term benefits. Capacities for health sector policy engagement include related competencies for implementing a Health in All Policies approach. Capacity-building of relevant health workforces on health, environment and climate change is also important in connection with universal health coverage and health emergencies.

(ii) **Stepping up health sector efforts to reach out to other sectors for health protection and promotion.** Because of the wide scope of issues and the broad range of engaged actors, it is important for the health sector to provide guidance and establish regulatory frameworks on the assessment of health risks and impacts, on the implementation of appropriate solutions and on monitoring progress across sectors.

(iii) **Ensuring essential environmental services and healthy workplaces in health care facilities, and greening the health sector.** In low- and middle-income countries, it is necessary to address the major deficit in equipping health care facilities with safely managed water, sanitation and hygienic practices as well as reliable energy supplies, and ensuring their resilience to extreme weather events and other emergency situations. The health sector also needs to lead by example when it comes to procurement policies and services, waste management and energy-related choices in order to limit any negative impact on health, the environment and climate change.

Strategic objective 4. Building support: to build mechanisms for governance, and political and social support

Governance mechanisms and political support at high level will enable work across sectors and maintain public goods for health. Citizens' demands for healthier environments will shape policy choices. Multilateral and other high-level agreements will tackle major driving forces of risks to health and global threats to health.

21. Governance mechanisms, agreements and political will need to be based on more holistic approaches including interdepartmental and intersectoral cooperation that can achieve positive outcomes across all the affected sectors. This would lead to policy choices based on their overall impacts, including health impacts, on society. Currently, sectors are mainly driven by their sector-specific goals.

(i) **Strengthening of governance mechanisms to allow sustainable health-protective action.** Efficient and overarching governance mechanisms can decisively facilitate cross-sectoral work and to take into account costs and benefits in a comprehensive way. More holistic approaches and the protection of goods for health, such as clean air or a stable climate, are aimed for, in coordination with the health sector. As returns from environmental health action are rarely aligned with political timetables, it is important that such mechanisms can also accommodate environmental action with long-term health co-benefits and returns. Such mechanisms usually have a higher sustainability than repeated health care.

(ii) **Stepping up demand and leadership for health.** Broad engagement and action are required of the health sector, stakeholders from other sectors and the community to implement health-supportive policies, together with healthy design and management of environments. Health impacts from environmental risks are substantial: conventional health care systems alone cannot sustainably address them. Society is less and less willing to accept the avoidable health impacts. Health in All Policies and whole-of-government approaches are useful in this process.

(iii) **Building high-level political movements and enabling agreements.** Long-term global efforts to address environmental risks to health have generated important evidence and tools. Evidence on solutions to reduce substantially the disease burden from unsafe environments has accrued: these notable successes are showing high returns on investments, such as benefits in terms of reduced air pollution and associated health gains from strategies to mitigate the effects

of greenhouse gas emissions, or the 5.5:1 return from investing in water and sanitation.¹ Recent high-level political forums, commitments and meetings have highlighted this evidence.

Strategic objective 5. Enhanced evidence and communication: to generate the evidence base on risks and solutions, and to efficiently communicate that information to guide choices and investments

Sufficient evidence-based information will be available in all critical areas to support choices in health-protective actions based on health impacts, economic implications of solutions, their effectiveness and co-benefits.

22. Enhanced cross-sectoral action, high-level support and scaled-up primary prevention will all require a solid and expanded evidence base on health impacts, costs, effectiveness and wider societal benefits of solutions, and will need to be informed by regular monitoring. Through expanded networks and partners strengthened and intensified advocacy for, broad communication of and awareness raising about the health benefits from action on health, environment and climate change are essential in order to trigger and sustain action.

- (i) **Integration of environmental monitoring and health surveillance in order to evaluate the health impacts from environmental risks and services.** Global and local trends of environmental quality indicators and health impacts will continue to provide evidence on how the environment is influencing human health and development, and to identify the areas where action matters most.
- (ii) **Development of evidence-based guidance to support effective action at the national and subnational levels.** The health and other relevant sectors have the responsibility to collaborate with policy-makers about health impacts and economic evaluation of interventions, including legal instruments, to tackle the impact of the environment on disease. For example, more systematic reviews on cost-effectiveness of policies to address environmental health priorities would be central to decision-making. Interaction with implementers is necessary to optimize subsequent implementation. Targeted tools will need to be available for key stakeholders, to guide action for health.
- (iii) **Interpretation and targeted communication of evidence.** Evidence-based public health information on evidence and trends, messages, advocacy initiatives and campaigns will aim to inform stakeholders at various levels, support policy decisions and trigger high-level political action and support. Making evidence-based information widely known among citizens, with the support of the health workforce, for instance on human exposure to chemicals in consumer products or on the health risks of air pollution to people living in polluted areas and potential solutions, creates awareness, participation and demand for healthier environments. Citizens' demands and actions should in turn trigger action from decision-makers. Health professionals have an important role to play in promoting behavioural change towards healthy and more sustainable ways of living. Increasing knowledge of health risks and protective actions also supports efforts by citizens to take adaptive actions and to reduce polluting behaviours.
- (iv) **Mechanisms and capacity for early identification of and response to possible emerging threats to health.** Capacity must be built and mechanisms developed to deal with the possibility of rapidly emerging environmental health issues linked to new technologies, organization of work

¹ WHO. Global costs and benefits of drinking-water supply and sanitation interventions to reach the MDG target and universal coverage. Geneva: World Health Organization; 2012 (https://www.who.int/water_sanitation_health/publications/global_costs/en/, accessed 26 March 2019).

or global environmental changes. The extent and danger of some of these potential threats is uncertain; these include those relating to climate change, pharmaceuticals that persist in the environment, endocrine disruptors, microplastics, some nanoparticles and electronic waste. Building capacity and developing mechanisms will require authoritative reviews of evidence and assessment of the effectiveness of control measures, as well as targeted environmental monitoring linked to public health surveillance. It also includes the adoption of more cross-sectoral solutions, such as protection of biodiversity and ecosystem services, and the linked surveillance of pathogens in wildlife and human beings, in order to lower risk and increase preparedness for health threats resulting from human influence on natural ecosystems.

(v) **Shaping research and driving innovation.** Research is the foundation of strategic shifts, which will be necessary to accelerate attainment of the Sustainable Development Goals. To advance the 2030 Agenda on Sustainable Development, research needs must be identified and knowledge translated to fill critical knowledge gaps through the coordinated facilitation of research. Such research in environmental health has long been underfunded, particularly in comparison to biomedical research. Research connected to policies in health-relevant areas and in implementation science, relevant to all regions, will be of particular interest for improving health through safer and healthier environments. Innovation is needed to better monitor, prevent and respond to existing and emerging environmental risks to health. Scientific, social, financial and policy innovations can become decisive in accelerating health gains due to healthier environments.

(vi) **Building the case for adequate funding allocation and influencing investments.** Scaling up health-protective action for safer environments requires adequate funding and reorientation of investments. Funding allocation, and pricing structures and subsidies, should be guided by evidence-based assessments, for example of vulnerability and adaptation to climate change, taking into account all costs and all co-benefits. The full societal costs of inaction over short and long time-frames, and the implications of health-relevant policies in all sectors, need to be fully and systematically considered to prevent the hidden transfer of costs to the health sector and the undermining of environmental sustainability.

Strategic objective 6. Monitoring: to guide actions by monitoring progress towards the Sustainable Development Goals

Actions will be guided by monitored progress in the implementation of primary prevention through healthier and safer environments.

23. Monitoring will aim at using and analysing existing data and closely tracking changes in determinants of health and their impacts, as well as their distribution across and within population groups. It will thereby provide information on the rate of progress in order to adjust policies, including those for environmental justice.

(i) **Monitoring of progress towards the Sustainable Development Goals and their and other indicators.** Countries, in cooperation with WHO and other relevant organizations where appropriate, will continue to monitor progress towards the health-related Goals and other relevant indicators of health, environment and climate change, in order to deal comprehensively with the upstream determinants of disease. Strategic disaggregation of data will ensure the identification of health inequalities and their drivers. Strategic compilation of data, on social and environmental determinants to understand the drivers of health inequalities, will contribute to the development of policy coherence at all levels of government.

- (ii) **Monitoring change and implementation of relevant strategies at the regional and country levels.** Relevant impact and outcome indicators need to be monitored to measure change at the country level in order to assess progress and guide policies.

IMPLEMENTATION PLATFORMS

Specific entry-points will be used to deliver scaled-up action on environmental upstream determinants of disease using integrated approaches.

24. The response to the challenges of persistent and emerging health risks goes beyond the formal health sector. The response can only meet the scale of the challenges if it is led by the health community, participating in key strategies and planning, working with others to implement health-promoting multisectoral policies, in key sectors and settings. This response needs to be underpinned by public support and an enabling policy environment, informed and tracked with the best available evidence. A range of implementation mechanisms and platforms is required to achieve this vision. These are outlined below.

An empowered health sector

25. The formal health sector represents a significant and growing fraction of the global economy. It is one of the world's largest employers, with a unique position of trust and integration into communities. It is therefore ideally placed: to implement environmental health interventions at the community level (either directly or in partnership with civil society organizations); to lead by example in demonstrating good practice in sustainability, by reducing the environmental impact of health care practice; and to act as leaders and advocates for health and sustainable development. This will require: a rebalancing of health sector expenditure towards primary prevention over the long term; additional funds that could originate from the removal of harmful subsidies and reconfiguration of taxes to reflect all the consequences of policies and reduce inequalities; a global reinvigoration and broadening of the discipline of environmental health to address the scale and complexity of modern environmental health challenges, including adequate training of health professionals; health sector leadership to promote a vision of health with a longer-term perspective that focuses on health determinants; and health professionals to promote behavioural change towards more sustainable and healthier ways of living.

Stronger national and subnational platforms for cross-sectoral policy-making

26. A few countries have formal institutional structures that provide direct policy guidance on health and environment challenges or that mandate intersectoral assessments of the health implications of decisions taken in other sectors. Such a Health in All Policies approach needs to have broader coverage, upstream policies that include strategic assessments rather than individual projects, and more direct influence on policy (for example, a legal rather than only advisory status). High-level regional forums have also been greatly contributing to advancing the health and environment agenda.

Key settings as sites for interventions

27. Key settings present opportunities to deal with environmental health risks and reduce health inequalities, while responding to demographic, social, economic, technological and lifestyle changes. The main settings and the objectives of interventions are set out below.

- **Households.** To ensure that shelter: is structurally sound; has adequate indoor temperatures; provides adequate water, sanitation and illumination and has sufficient space; is equipped with clean, affordable and reliable energy for cooking, heating and lighting, and ventilation; and

protects from injurious hazards, noise, mould, pests and indoor contaminants, including harmful exposure from household and consumer products.

- **Schools.** To ensure a safe and health-promoting environment for education; to use schools as centres to generate awareness about the linkages between health and environment, including chemical risks, and provide education on healthier and more sustainable approaches; and to facilitate the inclusion of best practices in the wider community.
- **Workplaces.** To ensure coverage of occupational health services that deal with the full range of physical, chemical, biological, psychosocial and ergonomic risks at the workplace; that contribute to prevention and control of modifiable risk factors, in particular for noncommunicable diseases; and that are adapted to the new forms of work, migration and organization of workplaces, including in the informal economy and precarious workplaces.
- **Businesses.** To act as advocates for mitigation of and adaptation to climate change; businesses can play a positive role in this area.
- **Health care facilities.** To ensure: provision and sustainable management of essential environmental health services, including access to clean and reliable energy and safe water, sanitation and hygiene practices; resilience to extreme weather events and the effects of climate change; and protection of health care workers and the wider community, through chemical safety, infection control and waste management.
- **Cities.** To meet the particular challenges of cities, namely, their concentration of environmental exposures to risks, including ambient air pollution, urban heat islands, harmful chemicals, noise, vector-borne diseases,¹ poor sanitation, wastes or occupational risks, while making use of the opportunity presented by having a single authority under a city mayor who is empowered to take cross-sectoral decisions, for example on urban planning, purchasing, supply of energy, water and sanitation, and waste management. Rapid urbanization presents a particular challenge. Strategic urban planning will be the key to creating health-supportive environments.

28. This list is not exhaustive: additional relevant settings may include agricultural development areas, concentrated economic zones, refugee camps including temporary shelters and shelters for migrants, markets, villages and small islands.

Partnerships for a social movement for healthier environments

29. An essential requirement for action is political will. This can only come about through broad societal awareness of the fundamental health threats posed by environmental risks and climate change, and their potential solutions. Individual advocates, health professional associations and civil society organizations are crucial for mobilizing public support for more sustainable and health-promoting development choices.

Multilateral environmental, health and development agreements

30. Most global environmental agreements (such as the United Nations Framework Convention on Climate Change and the Paris Agreement, the Convention on Biological Diversity, the Minamata

¹ See also WHO, UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases. Global vector control response 2017–2030. Geneva: World Health Organization; 2017 (<https://www.who.int/vector-control/publications/global-control-response/en/>, accessed 26 March 2019).

Convention on Mercury, the Stockholm, Basel and Rotterdam conventions on hazardous chemicals and wastes), regional environmental agreements (including the Convention on Long-range Transboundary Air Pollution) and international labour conventions on occupational health and safety cite threats to health as a major concern. However, the mechanisms for implementing these agreements do not always adequately include consideration of these health threats or reflect health concerns, at national, regional or international levels. Stronger engagement of the health sector would promote synergies, minimize unintended negative consequences and optimize any necessary trade-offs between health, environmental and economic objectives. Similarly, ensuring that environmental risks are fully covered and action to counter them is supported in the national implementation of international health instruments, such as the International Health Regulations (2005), would particularly enhance and augment capacities to prevent, prepare for and respond to environmental emergencies. Such integration would advance the holistic approach articulated in the 2030 Agenda for Sustainable Development.

Platforms for the Sustainable Development Goals

31. The adoption of the 2030 Agenda for Sustainable Development has led to the creation of high-level political forums that are strengthening the means of implementation and follow-up on commitments made. Many of the Goals are entirely supportive of and in line with the actions to be taken to create a healthy environment. Such forums therefore constitute key platforms for triggering progress towards action on upstream environmental causes of disease and equitable health promotion. The main Sustainable Development Goals for health, environment and climate change, in addition to Goal 3 (Ensure healthy lives and promote well-being for all at all ages), include Goal 1 (End poverty in all its forms everywhere), Goal 2 (End hunger, achieve food security and improved nutrition and promote sustainable agriculture), Goal 6 (Ensure availability and sustainable management of water and sanitation for all), Goal 7 (Ensure access to affordable, reliable, sustainable and modern energy for all), Goal 8 (Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all), Goal 11 (Make cities and human settlements inclusive, safe, resilient and sustainable), Goal 12 (Ensure sustainable consumption and production patterns), and Goal 13 (Take urgent action to combat climate change and its impacts) in the context of Goal 10 (Reduce inequality within and among countries).

Evidence and monitoring

32. A limited number of countries have advisory bodies with the mandate and capacity to set national research agendas, generate syntheses of available evidence, track national progress on health and the environment, and provide this information directly to policy-makers. At the international level, the Intergovernmental Panel on Climate Change carries out this function in relation to the implication of climate change for health but institutionally similar functions for other environmental challenges are less comprehensively covered and more fragmented. The Working Group on Effects under the Convention on Long-range Transboundary Air Pollution of the Joint WHO/Convention Task Force on the Health Aspects of Air Pollution for the Pan-European Region is another example. National and international institutions, such as research institutes, universities, and sources such as peer-reviewed journals could also play a significant role in the definition of national strategies. Greater coverage, in terms of the numbers of countries with such mechanisms, and the range of environmental risks addressed, either individually or together, would greatly advance evidence-based policy-making. All such efforts should be aligned with and contribute directly to the monitoring of the Sustainable Development Goals at the national and international levels.

WHO'S ROLE AND LEADERSHIP IN GLOBAL HEALTH

33. The Secretariat's actions under the global strategy on health, environment and climate change are based around the three strategic priorities of WHO's Thirteenth General Programme of Work, 2019–

2023 (see Box 1). The basic health, environment and climate change activities fall under the strategic priority “Promoting healthier populations”, but the contribution to “Addressing health emergencies” has also proven to be substantial. WHO’s strategic priority of “Achieving universal health coverage” should underlie mechanisms for implementing basic environmental health services, such as access to safe drinking-water and clean fuels.

Box 1. The health, environment and climate change strategy and WHO’s Thirteenth General Programme of Work, 2019–2023

1. In WHO’s corporate strategy, three strategic priorities drive WHO’s contribution to ensuring healthy lives and promoting well-being for all at all ages. The three strategic priorities, with a description of how health and environment contributes to each of them, are:

- (i) *Achieving universal health coverage.* Essential environmental health services, knowledge and capacities need to constitute an integral part of universal health coverage.
- (ii) *Addressing health emergencies.* Improved resilience of the health sector and communities to climate change, reduced vulnerabilities, and enhanced preparedness, surveillance and response to health emergencies will prevent and reduce the health impacts of environmental emergencies.
- (iii) *Promoting healthier populations.* Conditions for healthier populations include: healthier cities; sustainable provision of safe water, sanitation and hygiene practices; healthy transport solutions; clean energy policies; sustainable food; safe and sustainable products, housing and workplaces; and sustainable agriculture.

34. WHO’s mandate in global health is derived from its Constitution and is further detailed in its Thirteenth General Programme of Work, 2019–2023: “Broad and sustained efforts are needed to build a community to work for the shared future of humankind, empowering all people to improve their health, address health determinants and respond to health challenges.”¹ To work towards that vision, the strategic objectives cover actions by, or with key input of, the health sector, in terms of primary prevention, cross-sectoral action on health determinants, leadership on health matters with reference to determinants of health, and health-related monitoring. To support these objectives, the Secretariat focuses on providing support to the health sector, and on multisectoral action on health determinants. Activities in this strategy are fully inscribed in WHO’s core functions.² WHO’s mandate, capacity and convening power therefore create the strengths and relative advantages to take the lead on the matters covered by this strategy. WHO’s activities in this strategy are structured into (a) leadership and policy support; (b) evidence synthesis and advocacy; and (c) provision of direct country support. Although WHO’s core functions continue to provide the foundation of its work (see Fig. 2 for a depiction of WHO’s role), important shifts need to be made to respond to evolving requirements and are detailed

¹ The Thirteenth General Programme of Work further states “WHO will advocate for health at the highest political level”, “WHO will speak up against practices from any sector including industry that, based on evidence, are harmful to health”, “The United Nations reform agenda should enable WHO to work more effectively with non-health sectors at the country level to address the health impacts of climate change and the environment, and of other factors that have a major impact on health”, and “With respect to air pollution (i.e. outdoor, household and workplace air pollution) and climate change mitigation, WHO will scale up its work with different sectors – including transport, energy, housing, waste, labour and urban planning – at the national and local level to monitor air quality, develop strategies for transitioning to healthier technologies and fuels and for ensuring that all populations breathe air that meets the standards of WHO’s air quality guidelines, and that scientific evidence will be translated into effective policies.”

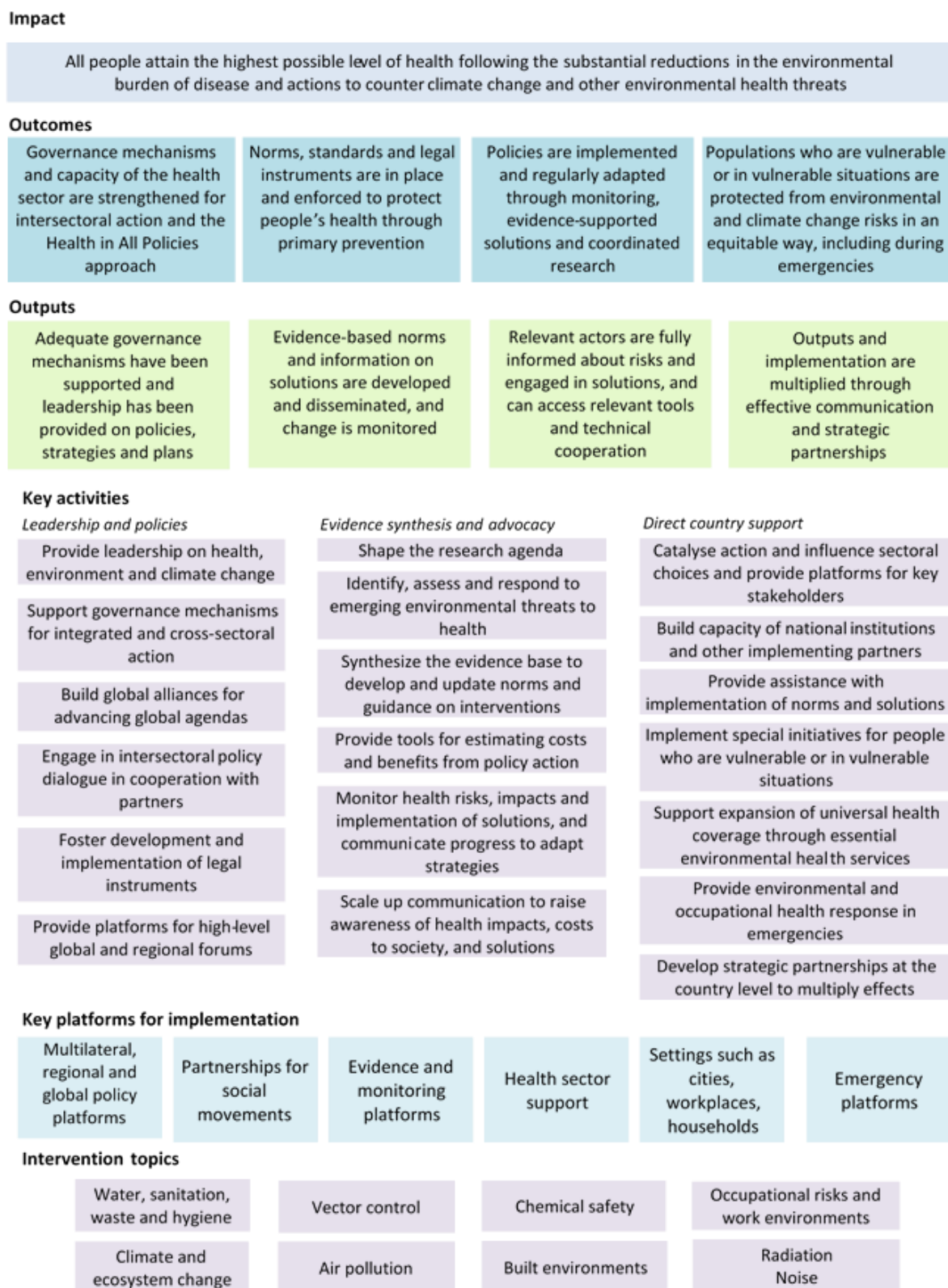
² Providing leadership on matters critical to health and engaging in partnerships where joint action is needed; shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge; setting norms and standards, and promoting and monitoring their implementation; articulating ethical and evidence-based policy options; providing technical support, catalysing change, and building sustainable institutional capacity; and monitoring the health situation and assessing health trends (WHO’s Thirteenth General Programme of Work, see http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf?ua=1, accessed 27 March 2019).

below. Close cooperation with relevant organizations in the United Nations system will be ensured through various mechanisms,¹ and cooperation is already active on various activities.²

¹ For example, the Health, Environment and Climate Change coalition, coordinating work across relevant United Nations agencies (see <https://www.who.int/globalchange/coalition/en/>, accessed 27 March 2019).

² For example, for clean air through the Breathelife campaign of WHO, United Nations Environment Programme and the Climate & Clean Air Coalition (<http://breathelife2030.org/>, accessed 27 March 2019) and the WHO/UNICEF Joint Monitoring Programme (<https://washdata.org/>, accessed 27 March 2019).

Fig. 2. Outline of WHO's role and leadership in health, environment and climate change



Promoting healthier populations

35. Under this strategic priority, WHO will undertake the following activities.

Provide leadership

- (a) Provide leadership in guiding healthy energy transitions, healthy transport and urban design solutions, a safe and healthy circular economy and other ongoing transformations, by combining WHO's evidence-based guidance and enhanced advocacy. Foster high-level political support, in interactions with Member States and civil society.
- (b) Coordinate regional policy processes by providing or expanding regional platforms for environment and health governance, bringing together key sectors and stakeholders.
- (c) Stimulate good governance to develop healthy and sustainable cities.
- (d) Ensure that the "voice of health" is heard. It is important that the health sector is actively engaged in the subsequent implementation of instruments, for example through WHO's Road map to enhance health sector engagement in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond which will contribute to achieving the sustainable development goals globally¹ and the Paris Agreement on climate change.

Synthesize evidence and advocate for building global goods for health

- (e) Ensure knowledge generation by catalysing and coordinating the expansion of the evidence base on norms, innovative and efficient solutions, research steered towards policy relevance, and emerging environmental threats to health. Evidence-based information on policy impacts will be essential to supporting cross-sector action and providing convincing arguments for seeking out co-benefits. The knowledge generated will then be synthesized into normative guidance to ensure the availability of goods for health, such as safe water and clean air, or safe products and technologies, such as consumer goods. The Secretariat will help to develop and sustainably extend innovative solutions in order to accelerate the reduction of environmental health risks.
- (f) Disseminate evidence-based information for maximizing consideration of health in decision-making. Information creates awareness about health risks and available solutions, and triggers demand for healthier environments.
- (g) Monitor change in risks to health and implementation of solutions – in terms of implementation rate, impacts, financial costs and cost-effectiveness. Continuous monitoring in order to realign priorities and implementation strategies in countries is needed. WHO will continue to expand its work in convening partners to develop data platforms that integrate the diverse data needed to monitor progress. WHO is also reporting on several indicators on health and the environment (within Goals 3, 6, 7 and 11).

¹ WHO. Road map to enhance health sector engagement in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond. Geneva: World Health Organization; 2017 (<http://apps.who.int/iris/bitstream/handle/10665/273137/WHO-FWC-PHE-EPE-17.03-eng.pdf?ua=1>, accessed 27 March 2019).

Enhance WHO's direct impact in countries

(h) Catalyse action for safer environments and influence sectoral choices, for example, through engaging in policy dialogue, providing guidance on healthy policies and governance mechanisms, and assisting in implementation of standards, and monitoring. The type of multisectoral and health-sector engagement will be tailored to countries' needs, and may vary in focus between upstream actions (policy-related and strategic) and downstream actions (such as technical cooperation). Activities will be closely coordinated with the work of other relevant organizations in the United Nations system (the One-United Nations approach) and partners.

(i) Enhance the capacity of the health sector to fulfil its increasingly crucial functions of stewardship, leadership and coordination in health matters with cross-sectoral scope. Assist in the development of plans for implementation of WHO's strategies on health, environment and climate change at national and regional levels. Support related resource mobilization efforts. Support monitoring of key environmental risks to health and of progress in implementing solutions. Also lead by example in order to limit impacts of the health sector on health, the environment and climate change, in other words green the health sector.

(j) Provide platforms for key stakeholders in shaping healthy choices related to the environment and climate change. Provide data, information and advocacy material (such as the Breathelife campaign)¹ to civil society in order to support their engagement in matters concerning healthy choices in relevant policies. Support mayors and other local key actors in shaping health-supportive environments by providing tools and information on healthy choices. Develop platforms facilitating the sharing of data, solutions and experiences between major stakeholders and countries.

(k) Develop special initiatives for populations in situations of vulnerability. Provide enhanced support to those who are vulnerable or in vulnerable situations (such as children whose development can be affected by environmental risks, especially early life exposures, and long-term effects, workers in the informal economy, populations living in emergency situations, poor communities, populations of small island developing States and least developed countries, the Arctic, water-stressed and low-lying areas and others in their specific context). Provide this support by strengthening health systems' resilience to climate risks, aiding efforts to adapt to climate change, and promoting measures to mitigate the effects of climate change around the world so as to ensure the long-term future of the most vulnerable.

(l) Provide emergency response. Support countries in developing systems to be prepared for environmental disasters and emergencies and to provide normative and technical guidance. Strengthen global and regional networks of experts to provide support to countries in responding to environmental emergencies. Responding to environmental health emergencies and delivery of environmental health services represent additional important activities in countries.

Addressing environmental health emergencies

36. Man-made conflicts, technological incidents and natural disasters take a toll on people's lives and health around the world, with climate change and forced migration being likely to further intensify such emergency situations. The number of displaced people fleeing emergencies is increasing, with the greatest effects being felt in countries with the worst environmental health conditions and the least

¹ See paragraph 34 above.

capacity to respond to environmental health emergencies. Preventing and managing such emergencies is essential to health security in order to keep people safe.

37. A systematic approach to environmental emergencies, such as a chemical or nuclear release, and to the environmental health aspects of all types of emergencies and disasters requires the Secretariat to work with all Member States to invest in assessment of vulnerability and risk, as well as planning for preparedness, response and recovery. The International Health Regulations (2005) provide a readily available vehicle to build national and regional capacities in core competencies pertinent to the detection of, preparedness for and response to chemical, zoonotic, radiological and nuclear events.

38. The objectives for environmental health management in emergencies are as follows:

- (a) identify, assess and map environmental and occupational health risks and vulnerabilities in countries susceptible to crisis
- (b) improve capacities to effectively prepare for and manage the environmental and occupational health aspects of emergencies, for instance by enhancing the resilience of health systems and facilities
- (c) ensure that health care facilities: have access to basic environmental health services, such as those for safe water, adequate sanitation and hygiene and to clean, reliable energy; are sited away from risk zones such as flooding; and have in place systems for managing occupational health and safety
- (d) protect people's health from environmental risks throughout the phases of the management cycle of the disaster or emergency.

39. Suggested priority actions for environmental health management in emergencies are outlined in Table 1.

Table 1. Suggested priority actions for environmental health management in emergencies

Strategic response	Action by Member States	Action by the Secretariat
Developing the capacities of the health sector to manage environmental and occupational health services throughout the life cycle of emergencies	<ol style="list-style-type: none"> 1. Develop environmental health emergency profiles (such as resource mapping and organization) and establish or update environmental health plans for emergencies 2. Operationalize policies, programmes and management systems pertinent to environmental health services in health care facilities, including the assessment, provision and restoration of services 3. Integrate the protection of occupational health and safety into national health security plans 	<ol style="list-style-type: none"> 4. Develop systems for the prediction and early warning of, and preparedness for, environmental disasters and manmade emergencies 5. Establish global and regional networks of qualified environmental and occupational health specialists and sanitarians who can be mobilized and deployed in a timely manner to provide support to countries in need 6. Build countries' capacities to protect occupational health and safety in public health emergencies
Providing adequate environmental health services in health care facilities during emergencies	<ol style="list-style-type: none"> 7. Strengthen the health sector capacity to develop and operationalize policies, programmes and management systems pertinent to environmental and occupational health services in health care facilities, refugee camps and other areas hosting internally displaced persons 	<ol style="list-style-type: none"> 8. Provide normative and technical guidance

Developing national capacities for responding to chemical, radiological and nuclear events for implementation of the International Health Regulations (2005)	9. Strengthen national capacities for responding to chemical, radiological and nuclear events. Leverage capacity-building in core capacities required by the International Health Regulations (2005)	10. Provide normative and technical guidance 11. Strengthen global and regional thematic networks of experts to provide support to countries in monitoring and responding to chemical and nuclear events
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Achieving universal health coverage by providing environmental health services

40. One of WHO's strategic priorities is to provide support to countries in making progress towards universal health coverage. Universal health coverage includes ensuring that all people have access to and can use promotive and preventive health services appropriate to their needs, while not exposing the user to financial hardship. Essential environmental services with the main aim to improve health are an integral part of universal health coverage. Such services include, for example, provision of drinking water of safe quality, safely managed sanitation services, clean energy and technologies, and workforce protection, both within health care facilities and within communities.

41. Essential health services will be the key to reducing outbreaks of infectious diseases (resulting, for example, in a reduction in the number of individuals with diarrhoeal diseases, following improved water and sanitation services) and noncommunicable diseases (for example, cardiovascular and chronic respiratory diseases through clean energy and technologies in households).

Goals to be achieved

42. Within the global strategy, the goals to be achieved by the transformational approach are highlighted in Box 2.

Box 2. Goals to be achieved by the transformational approach

To sustainably improve lives and well-being through healthy environments

1. **People.** People live longer and healthier lives owing to the reduction of environmentally-related diseases. People are aware of the environmental exposures harming their lives and how to avoid them, and of the benefits of more sustainable choices and make their voice heard by policy-makers. This ultimately leads to **better health and well-being**.
2. **Universal health coverage.** People benefit from **primary prevention** measures, such as essential environmental and occupational health services and health promotion, as an integral part of universal health coverage.
3. **Air pollution.** Countries and major cities have set health-based **air-quality targets** and have put in place policies to achieving the targets by **involving relevant sectors**. Polluting **fuels** and inefficient **technologies** are no longer used. Emissions have been significantly reduced.
4. **Climate change.** Health systems and communities around the world are **resilient** to climate variability and change, and drive down rates of climate-sensitive infectious disease. Carbon emissions are reduced to meet international commitments. Cleaner **energy systems** are built, efficient **public transport systems** promoting **active movement** are in place, **disease vectors** are appropriately controlled, more sustainable **diets** and more resilient **food systems** are promoted and implemented, and homes and workplaces should be buildings fit for health in a changing climate.
5. **Water, sanitation and hygiene.** All countries have incorporated the pillars of the **Water and Sanitation Safety Planning** into their strategies and have adequate hygiene integrated into the water safety plans. All health-care facilities have access to safe water, sanitation and hygiene. Sanitation and waste-water barriers to **combat antimicrobial resistance** are in place.

6. **Chemical safety. Impacts on health** from exposure to chemicals are reduced, as the health impacts from exposure to chemicals and their mixtures are **better known**, the use of chemicals is well regulated, national institutions have the **capacity** to meet chemical threats, including incidents and **emergencies**, and are involved in chemicals **management activities**.
7. **Radiation safety.** Health impacts from **ultraviolet radiation** are **decreasing** through better awareness of risks and through better personal protection. Unnecessary exposures from **medical imaging techniques** are eliminated. Lung cancers from exposure to **radon** are reduced through efficient preventive measures. **Nuclear incidents** are adequately responded to and managed.
8. **Health care settings.** All health care facilities and services are environmentally sustainable: using **safely managed water and sanitation services and clean energy**; sustainably managing their waste and procuring goods in a sustainable manner; are **resilient** to extreme weather events; and capable of protecting the health, safety and security of the **health workforce**.
9. **Workplaces.** All workplaces have systems in place for the management of **occupational health and safety** and for **promotion** of health at work. All workers have access to essential interventions for the prevention and control of occupational and work-related diseases and injuries.
10. **Global and regional settings.** International agreements and policies are in place as appropriate that efficiently deal with **global and regional drivers of health**, such as climate and ecosystem change.
11. **Emergencies.** All countries have the capacity to **manage environmental health services** effectively throughout emergencies. Countries have the capacity to **respond** to chemical, radiological and nuclear events and to **protect** the occupational health and safety of emergency responders.
12. **Governance.** National and local governments (for example, of cities) have mechanisms in place that facilitate **cross-sectoral cooperation** and integrate **health in all relevant policies** and ensure that they fulfil their obligations to provide safe environments for their citizens.

43. The WHO website provides access to supporting documents and details of activities in the Secretariat's priority intervention areas, including translations.¹

MEASURING PROGRESS TOWARDS THE SUSTAINABLE DEVELOPMENT GOALS

44. The main targets for measuring progress for the period 2019–2023, aligned with WHO's Thirteenth General Programme of Work, are listed below:

Within Goal 3 (Ensure healthy lives and promote well-being for all at all ages)

- reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

Within Goal 6 (Ensure availability and sustainable management of water and sanitation for all)

- provide access to safely managed drinking water services for one billion people
- provide access to safely managed sanitation services for 0.8 billion people
- reduce by 40–50% the number of people in low- and middle-income countries served by hospitals without reliable electricity and basic water and sanitation services

Within Goal 13 (Take urgent action to combat climate change and its impacts)

¹ See Public health, environmental and social determinants of health (<http://www.who.int/phe/publications/global-strategy/en/>, accessed 27 March 2019).

- double the amount of climate finance for health protection in low- and middle-income countries
- reduce by 10% mortality from climate-sensitive diseases (through climate change action rather than other drivers).

45. Additional and more detailed indicators are being monitored within each of the environmental health areas. The main health-related Sustainable Development Goals and indicators are listed in Box 3.

Box 3. The main Sustainable Development Goals and their targets and indicators linked to health and the environment^a

Goal 1 (End poverty in all its forms)

Target 1.5 by 2030, build the resilience of the poor and those in vulnerable situations, and reduce their exposure and vulnerability to climate-related extreme events and other economic, social and environmental shocks and disasters

Goal 2 (End hunger, achieve food security and improved nutrition and promote sustainable agriculture)

Goal 3 (Ensure healthy lives and promote well-being for all at all ages)

Indicator 3.9.1 Mortality rate attributed to household and ambient air pollution^b

Indicator 3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services^b

Indicator 3.9.3 Mortality rate attributed to unintentional poisoning^b

Goal 6 (Ensure availability and sustainable management of water and sanitation for all)

Indicator 6.1.1 Proportion of population using safely managed drinking water services^b

Indicator 6.2.1 Proportion of population using (a) safely managed sanitation services and (b) a hand-washing facility with soap and water^b

Indicator 6.3.1 Proportion of wastewater safely treated

Indicator 6.a.1 Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan

Indicator 6.b.1 Proportion of local administrative units with established and operational policies and procedures for participation of local communities in water and sanitation management

Goal 7 (Ensure access to affordable, reliable, sustainable and modern energy for all)

Indicator 7.1.2 Proportion of population with primary reliance on clean fuels and technology^b

Goal 8 (Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all)

Indicator 8.8.1 Frequency rates of fatal and non-fatal occupational injuries, by sex and migrant status

Goal 9 (Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation)

Goal 11 (Make cities and human settlements inclusive, safe, resilient and sustainable)

Indicator 11.6.2 Annual mean levels of fine particulate matter (e.g. PM2.5 and PM10) in cities (population weighted)^b

Goal 12 (Ensure sustainable consumption and production patterns)

Goal 13 (Take urgent action to combat climate change and its impacts)

Goal 17 (Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development)

Systemic issues: Policy and institutional coherence

Indicator 17.14.1 Number of countries with mechanisms in place to enhance policy coherence of sustainable development

^a Indicators in italics are those for which WHO is the custodial agency. Note that this list is not exhaustive: many more Goals and their indicators are linked to health.

^b Indicators included in WHO's Impact Framework.

ACTION BY THE HEALTH ASSEMBLY

[This paragraph contained one draft decision, which was adopted by the Health Assembly as decision WHA72(9).]

ANNEX 3

Plan of action on climate change and health in small island developing States¹

[A72/16 – 25 April 2019]

BACKGROUND

[Paragraphs 1–7 described the background to the plan of action, including the process of its development.]

VISION

8. This plan of action has a vision that by 2030 all health systems in small island developing States will be resilient to climate variability and change.
9. This vision must be realized in parallel with the steps taken by countries around the world to reduce carbon emissions, in order to both protect the most vulnerable from climate risks and gain the health co-benefits of mitigation policies.

SCOPE

10. The plan of action aims to provide national health authorities in small island developing States with political, technical, capacity-building and financial support, and the evidence needed to:
 - (a) better understand and address the effects of climate change on health, including those mediated via climate change impacts on the main determinants of health, for example, food, air, water and sanitation;
 - (b) improve the climate resilience and environmental sustainability of health services; and
 - (c) promote the implementation of climate change mitigation actions by the most polluting sectors, for example, transport, energy, food and agriculture, that will maximize health co-benefits, both within and outside small island developing States.
11. The plan of action also aims to lead the way in transforming health services in small island developing States away from a model of curative services with escalating costs and towards a model based on disease prevention, climate resilience, sustainability and community participation. Further aims are: to promote a more integrated way of working across different health programmes, such as, environmental health, worker's health, food security and nutrition; to contribute to overlapping objectives, including universal health coverage, health security and emergency preparedness and response; and to collaborate with other international and intersectoral partners, in line with respective comparative advantages.

¹ See decision WHA72(10).

12. The plan of action is designed to support WHO's special initiative on climate change and health in small island developing States, which is a voluntary grouping that includes small islands irrespective of their constitutional status, that is, it also includes independent States, overseas departments, dependencies and territories.¹

STRATEGIC LINES OF ACTION

13. The plan of action has four interlinked and mutually reinforcing strategic lines of action; each has two associated actions and two indicators for monitoring progress.

Strategic line of action 1 – Empowerment: Supporting health leadership in small island developing States to engage nationally and internationally

14. Health is increasingly recognized in climate discussions; nevertheless, it is still not routinely and formally identified as a priority, resulting in missed opportunities in both protecting and promoting health as an argument and a measure of success for climate action. There is a need to ensure that the necessary information on the connections between health and climate change is made available to Member States, so that it can be considered in establishing the official positions of relevant small island developing State groupings in the United Nations Framework Convention on Climate Change and other relevant sustainable development processes. Small island developing States constitute about one fifth of United Nations and WHO Member States and could leverage their strength in numbers to advocate more effectively for global action. The strategic line of action on empowerment aims to promote the voice of health leaders, on behalf of the most vulnerable populations, in support of adaptation in small island developing States and mitigation by countries around the world.

Action 1.1 – Establish at WHO a small island developing States hub or alternative coordination mechanism on small island developing States to provide support for action on climate change, environment and other priority health issues

15. This action will address the request from countries to identify and promote mechanisms that support an open process of engagement between small island developing States and WHO, and between small island developing States and other development partners. The action will support capacity building among policy-makers in climate change and health. The hub will also work with other partners to connect the issue of climate change to other health and development priorities, including tourism, environment, waste management, agriculture, fisheries and industry. Progress will be monitored against the following indicator:

Indicator 1.1 – Small island developing States coordination mechanism established in WHO for climate change, environment and other priority health issues

Action 1.2 – Provide health sector inputs (for example, national adaptation plans, national communications and nationally determined contributions) to the United Nations Framework Convention on Climate Change and stakeholders leading relevant national climate change processes

16. To implement this action, WHO will work to strengthen the monitoring of health issues within international conventions and agreements on the environment, and put in place regional risk assessment

¹ Reference elsewhere in this report to national adaptation plans and national communications is intended to include submissions by both independent States and overseas departments, dependencies and territories, either in their own right, or within those of their respective governing nations.

and risk communication mechanisms. Through the platform to address the health effects of climate change in small island developing States, WHO will work to ensure that health leaders in small island developing States are fully aware of the latest evidence regarding the relationship between climate change and health, and are empowered to highlight the threats and opportunities for action in national and international contexts. The Secretariat will also work to promote high-level engagement by working with Member States to include the small island developing States initiative in ongoing global and regional agendas, including the United Nations Framework Convention on Climate Change, implementation of the *2030 Agenda for Sustainable Development*, and regional Health and Environment ministerial fora. Progress will be monitored against the following indicator:

Indicator 1.2 – Number of small island developing States that include health as a priority in their most recent national communications, national adaptation plans or nationally determined contributions to the United Nations Framework Convention on Climate Change

Strategic line of action 2 – Evidence: Building the business case for investment

17. The global evidence base for the impacts of climate change on health is comparable to that for any other climate-sensitive outcome, for example, agriculture and water resources. However, the information is often not presented in an easily accessible form at the national or subnational level where most policy decisions are made. It also often lacks the systematic economic evidence base needed to make the case to potential investors, such as international climate finance institutions, development banks and national finance ministries. Finally, there is a lack of operational research on the implementation of climate change and health programmes in small island developing States and elsewhere.

18. In addition, limited human resources and research capacity in most small island developing States presents a challenge in generating new, locally relevant research. Hence, there is a need to ensure that existing evidence is connected as directly as possible to policy, and to build capacity and strengthen connections between national research institutions in small island developing States, as well as with research institutions outside those States and with policy-makers. This strategic line of action therefore aims to ensure that health ministries have the necessary health, environment and economic evidence to support scaled-up investment in climate change and health, identify priority investments and monitor their impact.

Action 2.1 – In collaboration with the United Nations Framework Convention on Climate Change, develop or update national climate and health country profiles for every small island developing State

19. In collaboration with the United Nations Framework Convention on Climate Change, WHO has already produced country profiles for 45 countries, including six small island developing States. The platform to address the health effects of climate change in small island developing States will work with partners to conduct new or updated climate change and health vulnerability and adaptation assessments. Progress will be monitored against the following indicator:

Indicator 2.1 – Number of small island developing States that have completed climate and health country profiles supported by WHO and the United Nations Framework Convention on Climate Change

Action 2.2 – Identify, support and build on existing centres of excellence in increasing capacity, conducting assessments, data analysis, research and implementation of actions, including with organizations and universities that have regional mandates

20. This action will include: estimating the cost of climate change impacts on health in small island developing States; working with partners to develop detailed investment plans informed by sound economic analyses of costs and gaps so as to increase the resilience of health care systems, including health care facilities; conducting operational research in parallel with implementation; and developing and implementing a research agenda, including by providing support for building research capacity in countries. Information on small island developing States will be better used in order to inform the global effort to reduce emissions. Progress will be monitored against the following indicator:

Indicator 2.2 – Number of collaborating centres actively engaged in supporting the platform to address the health effects of climate change in small island developing States

Strategic line of action 3 – Implementation: Preparedness for climate risks, adaptation, and health-promoting mitigation policies

21. The plan of action will build on the experience gained in climate and health adaptation projects around the world, in order to increase coverage of evidence-based interventions within a comprehensive approach based on WHO's operational framework for building climate resilient health systems. It also aims to strengthen the role of the health sector in promoting the health co-benefits of climate change mitigation actions implemented by those sectors with greater responsibility for global warming, both within and outside small island developing States.

22. This strategic line of action aims to bring about transformational change in health systems by promoting and supporting a culture of disease prevention, building the climate resilience of health systems, and maximizing the health co-benefits of climate change mitigation policies.

Action 3.1 – Support small island developing States through regional frameworks to build climate resilient health systems

23. This action includes preventive measures, such as, integrating into the implementation of universal health coverage protection of the environmental determinants of health, for example, water and food security, and strengthening surveillance and control of climate-sensitive diseases. It also includes a specific effort focused on climate resilient and environmentally sustainable health care facilities (building or retrofitting health infrastructure to become resilient to extreme weather events and ongoing climate change); ensuring reliable access to, and efficient use of, energy and water; and reducing emissions of greenhouse gases. The action will also entail baseline assessments and the development and implementation of climate mitigation plans for the health sector in order to reduce greenhouse gas emissions from energy, food, transportation and procurement. Progress will be monitored against the following indicator:

Indicator 3.1 – Number of small island developing States that have initiated actions for climate resilient, environmentally sustainable health care facilities

Action 3.2 – Develop and implement programmes to raise awareness and build capacity for adaptation and disease prevention both by people and health systems

24. To implement this action, WHO will support small island developing States in implementing national and subnational health adaptation plans within broader intersectoral climate change action plans. It will also facilitate information sharing, stocktaking and research, and conduct advocacy and awareness campaigns for health leaders, policy-makers, key stakeholders and the general public. The action will also require a strengthening of environmental health programmes so they make a full contribution to preventive health services and primary health care (including disaster risk management) and the control of communicable and noncommunicable diseases (including mental health). Progress will be monitored against the following indicator:

Indicator 3.2 – Number of small island developing States that have begun implementation of climate change and health national and subnational adaptation plans or actions to achieve the health co-benefits described in their nationally determined contributions to the United Nations Framework Convention on Climate Change

Strategic line of action 4 – Resources: Facilitating access to climate and health finance

25. A significant change in the current health vulnerability of the populations of small island developing States will not be possible without access to sufficient financial resources. Health ministers have prioritized the need to expand and diversify the funding streams potentially available to build health resilience into climate change. They have identified specific challenges, which include the following: the fact that the main climate finance mechanisms currently allocate only about 0.5% of resources to health; the complexity of accessing these funds; the fact that no health agencies are currently accredited to implement projects on behalf of such mechanisms; and that the eligibility of countries for some funding streams is linked to overall measures of economic development without due account being taken of the particular challenges facing small island developing States, such as, high per capita costs of providing health care and high economic vulnerability to extreme weather events.

26. This strategic line of action aims to facilitate access to climate finance, development assistance and domestic resources, with an aspirational goal of tripling the current level of investment in climate change and health in small island developing States over the period 2019–2023.

Action 4.1 – Lead a process to identify new and innovative forms of funding and resource mobilization mechanisms

27. This action will entail addressing the requests of Member States for support from WHO in identifying available resources to tackle climate-related health issues, and for transparency in accessing funds, including simplified funding mechanisms. The Secretariat will track and report on funding for climate change and health in small island developing States within existing climate and health finance streams, including WHO's own programme budget. To the extent that existing funds do not respond to the needs of small island developing States in addressing changes in climate and health, WHO will explore the possible establishment of a new fund for this purpose, as appropriate and in line with existing mandates. Progress will be monitored against the following indicator:

Indicator 4.1 – Number of small island developing States receiving financial support for climate change and health

Action 4.2 – WHO will pursue the process of becoming an accredited agency of the Green Climate Fund and facilitate support to small island developing States

28. Small island developing States have advocated for WHO to simplify mechanisms and overcome current complexities in obtaining funding for adaptation and mitigation in the health sector. The Secretariat will also continue to support countries by strengthening national leadership, advocacy and instruments to establish a clear process to access financing for climate change and health. Progress will be monitored against the following indicator:

Indicator 4.2 – Total funds received for climate change and health sector in small island developing States

MONITORING AND REPORTING OF PROGRESS

29. Progress in implementation of the plan of action will be monitored against the indicators defined above, primarily on the basis of survey information collected in consultation with countries, which also forms the basis of the climate and health country profiles supported by WHO and the United Nations Framework Convention on Climate Change. It is proposed that progress should be reported biennially to the Health Assembly over the period 2019–2025.¹

ACTION BY THE WORLD HEALTH ASSEMBLY

30. [This paragraph contained one draft decision, which was adopted by the Health Assembly as decision WHA72(10).]

¹ WHO regional committees may wish to consider separate monitoring arrangements for individual regional action plans.

ANNEX 4

Pandemic Influenza Preparedness (PIP) Framework for the sharing of influenza viruses and access to vaccines and other benefits: recommendations of the Advisory Group, and amended footnote to Annex 2 of the PIP Framework¹

A. Report and recommendations of the Pandemic Influenza Preparedness Framework Advisory Group from its meeting on 17–19 October 2018, Geneva, Switzerland²

Organization and process of the meeting

1. The Pandemic Influenza Preparedness (PIP) Framework Advisory Group (AG) met at the WHO headquarters in Geneva, Switzerland, 17–19 October 2018.
2. Of the 18 members of the AG, 17 were present. The list of AG participants in the meeting is available at Annex 1.
3. On behalf of the Director-General, the Director, Infectious Hazard Management welcomed the AG members and thanked them for their diligent work. The Deputy Director-General of Emergency Preparedness and Response conveyed his thanks and appreciation to the AG on the second day of the meeting.
4. The Chair thanked outgoing AG member, Dr Olav Hungnes, for his dedicated service and many contributions. The Chair also thanked the Secretariat for its good work.
5. Declarations of Interest were reviewed by the Secretariat and relevant interests were disclosed. The Statement of Declarations of Interests is available at Annex 2.
6. The agenda of the AG meeting was adopted and is available at Annex 3.
7. Two representatives from the WHO Global Influenza Surveillance and Response System (GISRS) Collaborating Centres (CCs) attended relevant technical meeting sessions in line with the arrangement for representation of GISRS at PIP Framework meetings.³ A third GISRS representative from a National Influenza Centre (NIC) was prepared to attend but travel arrangements were not completed in time. The list of participants from GISRS, manufacturers and industry associations, civil society organizations and WHO is available at Annex 4.

¹ See decision WHA72(12).

² Reproduced without annexes. The report including annexes is available at https://www.who.int/influenza/pip/AGMR_Oct2018.pdf (accessed 20 November 2019).

³ See http://www.who.int/influenza/gisrs_laboratory/GISRS_representation_20171010.pdf (accessed 20 November 2019).

Actions taken since April 2018 Advisory Group meeting

8. The Secretariat updated the AG on two specific actions taken in response to the AG's April 2018 recommendations to the Director-General. Updates on other actions taken are included in relevant technical sections (e.g. virus sharing).
9. The Secretariat reported on a meeting held by the Director-General and Deputy Director-General with CEOs of large vaccine and antiviral companies and the International Federation of Pharmaceutical Manufacturers & Associations (IFPMA) to discuss implementation of the PIP Framework. The Deputy Director-General followed up with two additional meetings.
10. In response to the 2016 PIP Review Group's recommendation to develop a Comprehensive Evaluation Model,¹ a 6-monthly PIP Framework Progress Report has been developed. Inclusion of the PIP Framework in the WHO Programme Budget Web Portal and the addition of an interim financial statement to the yearly version of the Progress Report addressed recommendations of the 2017 External PC Audit.

Recommendations to the Director-General on the Comprehensive Evaluation Model

11. *The AG recommends that the Director-General accept the 6-monthly Progress Report and the inclusion of the PIP Framework in the WHO Programme Budget Web Portal as meeting the 2016 PIP Review Group's recommendation to develop a Comprehensive Evaluation Model (Recommendation 1).*
12. *To maintain the visibility of the PIP Framework and its implementation, as requested by stakeholders, the AG recommends that the PIP Framework remain on the Programme Budget Web Portal as a distinct Special Project and not be aggregated into the WHO Health Emergencies Programme.*

Update on implementation of the Partnership Contribution

13. The Final Report on the PC High Level Implementation Plan (HLIP) I, which summarizes 2014–2017 achievements, will be published in October 2018. Overall, 81% of 21 HLIP I target indicators were met (i.e. >85% achieved) or exceeded.
14. The first Progress Report presented information on technical and financial implementation for HLIP II and the PIP Secretariat for January–June 2018. Progress for financial implementation is reported against the WHO biennial allocation. Information in the Progress Report is largely conveyed through infographics.
15. The AG noted that the Progress Report was an excellent and well-designed mechanism to convey detailed information on technical and financial aspects of PC implementation and outcomes.

¹ See PIP 2016 Review Group Report, Recommendation 1 at http://apps.who.int/gb/ebwha/pdf_files/EB140/B140_16-en.pdf?ua=1 (accessed 20 November 2019).

Update on collection of Partnership Contribution

16. The AG was briefed on the PC received from 2012–2018. Invoices for 2018 were sent in August. As of mid-September 2018, approximately 30% of the 2018 annual US\$ 28M contribution had been received.
17. Challenges persist in the collection of PC. Although most of the larger manufacturers have paid, a few are not paying their full invoiced amount. Several smaller companies have unpaid contributions. As a result, the annual PC (US\$ 28M) has had a 2%–4% shortfall each year through 2017.
18. The Secretariat continues to engage with industry on this issue and follows up with all companies that have outstanding PC amounts due.
19. The AG noted that it has made previous recommendations regarding PC collection, most recently at its April 2018 meeting.¹ The AG plans to continue monitoring this situation and, in future discussions, consideration will be given to appropriate steps, including with respect to access to PIP Biological Materials (PIPBM), to address concerns in this area.

Consultation with stakeholders on PIP Framework implementation

20. Headquarters and regional offices updated industry and other stakeholders on PC implementation activities since the last AG meeting and demonstrated the WHO Programme Budget Web Portal.
21. The Chair opened the Consultation by thanking stakeholders for their contributions to implementation of the PIP Framework.
22. The AG received the following comments from industry representatives:
 - a. Provided very positive feedback about the new 6-monthly Progress Report in terms of its readability, infographic format, linkage of activities to budget implementation and inclusion of an interim certified financial statement on an annual basis. The regional Impact Stories were particularly well-received.
 - b. Noted that the level and visibility of detailed information and Impact Stories are useful for them when communicating with their leadership about the importance of the Framework and the impact of PC.
 - c. Requested that the Secretariat share regional Impact Stories in advance of the AG stakeholder consultations and make them more widely available.
 - d. Suggested emphasizing “new” activities/accomplishments/advances as they provide evidence of PC-facilitated capacity improvement.

¹ See April 2018 AG meeting report at https://www.who.int/influenza/pip/advisory_group/PIPAG_MR_Apr2018.pdf?ua=1 (accessed 20 November 2019).

- e. Noted the importance of providing information on the sustainability of PC-funded achievements in future Reports.
 - f. Requested information on how the interest accumulated in the PC Response Fund account would be reported.
23. The AG received the following comments from the Third World Network (TWN):
- a. Provided very positive feedback on the Progress Report.
 - b. Sought clarifications on how regions approach PC-related staffing and on the plan for PIP Framework Secretariat staffing at headquarters.
24. Industry provided the following comments regarding implementation of decision WHA70(10)8(b):
- a. Re-iterated their views that i) the PIP Framework should not be expanded to include seasonal influenza; and ii) there should be no restrictions on the sharing of genetic sequence data (GSD), as “loopholes” are theoretical at this point and use of PIPBM is still necessary for bringing products to market.
 - b. Stressed that an urgent solution is needed to address the challenges and uncertainties for sharing of seasonal influenza viruses that have emerged as countries implement the Nagoya Protocol.
 - c. Noted that some Member States are exempting seasonal influenza viruses from the Nagoya Protocol and suggested that WHO work with States to facilitate sharing of information on how they are approaching seasonal influenza virus sharing under the Nagoya Protocol.
 - d. Requested clarification about the next steps for the document prepared for the 15–16 October 2018 Consultation on Implementation of Decision WHA70(10)8(b), *Approaches to Seasonal Influenza and Genetic Sequence Data Under the PIP: Draft Analysis* (the “draft *Analysis*”), including the process for transmittal to the Executive Board and World Health Assembly (WHA).
25. TWN provided the following comments regarding implementation of decision WHA70(10)8(b):
- a. Re-iterated their views that i) seasonal influenza should not be included in the scope of the PIP Framework; ii) there is little distinction between GSD and PIPBM; and iii) amending the definition of PIPBM to include GSD is their favoured approach.
 - b. With respect to the discussions between WHO and Member States about how they are approaching sharing of seasonal influenza viruses under the Nagoya Protocol, TWN reminded WHO of the sovereign rights that Member States have over their genetic resources.
 - c. Asked for clarifications about the process to finalize the draft *Analysis*.
26. GISAID noted its concern about paragraph 69 in the draft *Analysis* that relates to “Legal notice” and use of GSD.

27. Industry reported on progress to develop a revised formula for calculating the distribution of the PC among companies. They are waiting for information from one company before the formula can be finalized and shared with WHO and the AG. Industry indicated that they aim to provide this revised formula by the Spring 2019 PIP AG meeting.

Virus sharing

28. The Global Influenza Programme (GIP) provided an update on virus sharing.
29. In response to the AG's April 2018 recommendations for improving virus sharing, GIP intensified several actions including development of communication and outreach materials for health and non-health sectors and case-by-case engagement with countries jointly with the WHO CCs of GISRS, and WHO regional and country offices.
30. GIP presented an interim review of sharing of influenza viruses with human pandemic potential (IVPPs) from the adoption of the PIP Framework in May 2011 to 30 June 2017 and country-specific IVPP sharing from 1 July 2017 to 31 August 2018, according to the operational guidance which came into effect from 1 July 2017.¹
31. The AG discussed that IVPP sharing with and within GISRS occurs at two levels. Initially, IVPP is shared by a country, through its NIC or another influenza laboratory, with GISRS (often to a WHO CC) and then upon request with other GISRS laboratories. In addition, there is sharing with other laboratories. The AG emphasized that it is important to be able to assess the completeness and timeliness of sharing at all levels.
32. The AG observed that there are ongoing challenges with PIPBM sharing related to different, evolving, and sometimes conflicting, national regulations addressing import, export and security concerns. This sometimes hampers timely receipt and sharing of PIPBM.
33. The AG noted that some countries with human cases of IVPP infection continue not to share these viruses according to the virus sharing operational guidance. The AG plans to continue monitoring this situation and, in future discussions, consideration will be given to appropriate steps, including with respect to benefit sharing, to address concerns in this area.

Recommendation to the Director-General on virus sharing

34. *The AG requests that the Secretariat collect, analyse and present data on virus sharing in a way that enables a deeper understanding of potential problems that exist with virus sharing under the Framework.*

Indirect use of PIPBM

35. The PIP Secretariat sought the AG's advice about applying the Standard Material Transfer Agreement 2 (SMTA 2) benefit sharing process to influenza product manufacturers who may be indirectly using PIPBM in their product development/testing without being recorded as doing

¹ See Operational Guidance on Sharing Influenza Viruses with Human Pandemic Potential at <http://apps.who.int/iris/bitstream/handle/10665/259402/WHO-WHE-IHM-GIP-2017.3-eng.pdf;jsessionid=309A7D7464BA8B47D02B8ED251757D9A?sequence=1> (accessed 20 November 2019).

so, i.e. without an Influenza Virus Tracking Mechanism (IVTM) number which would track the use of the PIPBM.

36. This has occurred, and may continue to occur, where manufacturers of influenza products work with PIPBM recipients outside their organization to support development, testing or regulatory processing of their products. Such manufacturers would not appear in the IVTM, and therefore would not be contacted to sign an SMTA 2. This is considered an “indirect” use of PIPBM.
37. The AG noted that this scenario represents a loophole regarding access and benefit sharing and needs to be addressed.
38. The AG proposed a language modification in Footnote 1 of Annex 2 of the PIP Framework. The footnote language could be expanded to include the following bolded text:

“Recipients are all entities that receive ‘PIP Biological Materials’ from the WHO global influenza surveillance and response system (GISRS), such as influenza vaccine, diagnostic and pharmaceutical manufacturers, as well as biotechnology firms, research institutions and academic institutions and **entities that engage with recipients of PIPBM for the purpose of supporting development, testing or regulatory processing of an influenza-related product.** Each recipient shall select options based on its nature and capacities.”

Recommendation to the Director-General on addressing indirect use of PIPBM

39. *The AG recommends that the Director-General take the proposed revision in paragraph 38 of this meeting Report forward through the necessary steps to modify Footnote 1 in Annex 2 of the PIP Framework to address the loophole described above.*

WHO Consultation on Implementation of Decision WHA70(10)8(b)

40. Sixteen of the eighteen Members of the AG attended the Consultation on 15–16 October 2018.¹
41. The AG noted the high-quality and comprehensive draft *Analysis* prepared by the Secretariat and the Consultation that occurred over the course of the two days.
42. The AG also noted that, while discussions were robust, the number of Member States that participated was somewhat limited.² The Secretariat plans to continue consultations.

Seasonal influenza under the PIP Framework

43. The PIP AG was reminded that as per Annex 3 of the PIP Framework, it is mandated to provide guidance to the Director-General on strengthening the function of the Framework and the operational functioning of GISRS. WHO works to implement the Framework in the best interest of public health and with particular focus on Member States most in need.
44. The PIP AG noted that it is important to recall that:

¹ See <http://www.who.int/influenza/pip/ConsultWHA70108b-Oct18/en/> (accessed 20 November 2019).

² A total of 37 Member States registered to attend the Consultation.

- a. Pandemic influenza preparedness and response are closely connected to seasonal influenza surveillance and control, and
 - b. GISRS is an essential component of influenza preparedness and response – both seasonal and pandemic – and the PIP Framework is the mechanism for IVPP access and benefit sharing.
45. There are variations in how countries are implementing the Nagoya Protocol. In some instances, implementation of the Nagoya Protocol has delayed and restricted seasonal influenza virus sharing.
 46. There is a general lack of awareness of, and action on, the Nagoya Protocol’s potentially serious impacts on public health, not only for influenza, but for a broader set of pathogens. Minimizing these potential impacts requires a whole-of-government engagement, i.e. not restricted solely to Ministries of Health or Ministries of the Environment.
 47. At this stage, including seasonal influenza in the PIP Framework could pose risks to the integrity and good functioning of both the PIP Framework and GISRS. At the same time, issues have arisen with seasonal influenza virus sharing.

Recommendations to the Director-General on seasonal influenza under the PIP Framework

48. *The AG considers that, at this stage, it is not advisable to include seasonal influenza in the scope of the PIP Framework. The AG recognizes that there are ongoing discussions with Member States on this issue.*
49. *The AG recommends that a solution be developed urgently to address the challenges and uncertainties related to sharing of seasonal influenza viruses that have emerged as countries implement the Nagoya Protocol. In addition, the AG advises that the Secretariat closely monitor instances where implementation of the Nagoya Protocol is affecting the sharing of seasonal influenza viruses.*
50. *The AG encourages WHO to increase substantially and effectively its engagement with the Secretariat of the Convention on Biological Diversity (CBD) and Member States in the interest of promoting and advancing public health.*
51. *The AG encourages WHO to seek ways to mobilize a comprehensive approach to increase Ministries of Health’s awareness of Nagoya Protocol-related issues and to promote their engagement with the CBD processes, such as using the Regional Committees.*
52. *The AG encourages the Director-General to: i) communicate with Ministers of Health and Ministers of Foreign Affairs to promote cabinet-level attention to Nagoya Protocol public health-related issues; and ii) invite the 144th Executive Board to consider including an item on “the public health implications of implementation of the Nagoya Protocol” on the provisional agenda of the Seventy-Second World Health Assembly.*

Genetic sequence data under the PIP Framework

53. The AG recalled the four key principles developed over the course of its work on GSD, which included the formation of multiple working groups and discussions. These principles, grounded

in the Framework's foundational principle that access and benefits should be pursued on equal footing, are:

- a. There should be rapid sharing of high-quality GSD for timely risk assessment and response
 - b. There should be sustainable, public access to IVPP GSD
 - c. There should be fair and equitable sharing of benefits arising from the sharing of GSD
 - d. There should be acknowledgement of data providers and active collaboration between data providers and users.
54. The AG noted that various views on the relationship of GSD to the PIP Framework were expressed during the 15–16 October Consultation on Implementation of Decision WHA70(10)8(b), i.e. maintaining the current definition of PIPBM; modifying the definition of PIPBM through various approaches; or using other mechanisms for addressing GSD under the Framework.
55. At this time the AG advises that the current PIPBM definition should be maintained. However, the AG recognizes that further exploration is needed to understand the other approaches outlined in the draft *Analysis* related to this dynamic, technical area and their impact overall.
56. The AG noted that sharing of IVPP GSD is currently taking place, is functioning well, and that benefits include those derived from the PC and the ability to compare an IVPP sequence with a larger collection of IVPP GSD which can facilitate R&D.
57. The AG believes it is important to continue to strengthen access and benefit sharing related to IVPP GSD as Member States continue to discuss the larger policy issues and to promote the principles of fairness and equity. The AG also noted the increasing complexity of this topic which is closely interconnected with the way that science and medical research are conducted. It is therefore important to work transparently to address concerns.
58. At the current time there is a loophole related to the indirect use of PIPBM which is discussed in the section of this Report on "The Indirect Use of PIPBM". Some of these products could be derived solely from IVPP GSD. The recommendation made in paragraph 38 would close this loophole, including indirect uses involving IVPP GSD.
59. In the future it may be possible to bring to market influenza-related products using IVPP GSD independent of PIPBM. As a result, the obligation to sign an SMTA 2 would not be triggered. The AG recognizes that this is a concern.
60. To address this concern and to continue to strengthen IVPP access and benefit sharing, the AG wishes to revisit earlier work.
61. The AG previously had requested the Secretariat to investigate and develop a prototype search engine that would be able to track products developed using IVPP GSD. This search engine searches databases of patents, clinical trials and regulatory filings.
62. Based on the initial pilot of the prototype search engine, the AG now requests that the Secretariat expand this work to further assess the utility of this approach and report back. The AG requests

that the Secretariat begin to use this search engine on an experimental basis to identify products and ascertain the frequency and nature of those products that have not been subject to the benefit-sharing system, but potentially have made use of IVPP GSD. The AG hopes in this way to be able to make evidence-based recommendations that would contribute to strengthening approaches on benefit sharing with respect to IVPP GSD under the PIP Framework.

63. The AG's previous work highlighted the importance of the principle of the acknowledgment of data providers and active collaboration between data providers and users.

Recommendations to the Director-General on GSD under the PIP Framework

64. *The AG recommends that the Secretariat assess the utility of its prototype search engine to identify products which potentially have made use of IVPP GSD and have not been subject to the benefit-sharing system; determine the frequency and nature of such products; and report these findings to the AG.*
65. *The AG recommends that the Secretariat explore next steps to implement the principle of the acknowledgment of data providers and active collaboration between data providers and users. In particular, the AG recommends the development of appropriate language to be considered by relevant databases to inform potential users of IVPP GSD of the PIP Framework.*

Technical discussions

66. The Secretariat provided updates on the following:
 - a. Implementation of 2016 Review Group recommendations: The Secretariat reviewed the implementation status and actions taken or planned to implement the recommendations.
 - b. WHO finance briefing: The WHO Comptroller and two associates from the Finance Department provided an overview of WHO financial governance procedures to the AG. The Secretariat will develop a detailed biennial budget and activity plan for discussion by the AG at its Spring 2019 meeting. The discussion also touched on the topic of the interest accrued on the PC response funds.
 - c. University of Siena Training Workshop: The Secretariat provided an overview of a WHO training workshop on laboratory quality management and biosafety for NICs held at the University of Siena, Italy. The workshop originated from SMTAs 2 Category C training offers. Participants' knowledge of the training subject-matter, as measured by a written evaluation, increased by approximately threefold.

Next steps

67. The AG agreed that its next meeting will take place in the week of 11 March 2019.

The AG requested that certain technical matters not discussed at this meeting be included on the agenda for the next meeting.

B. Text of amended footnote 1 of Annex 2 of the PIP Framework¹

Recipients are receivers of “PIP Biological Materials” from the WHO global influenza surveillance and response system (GISRS), such as manufacturers of influenza vaccines, diagnostics, pharmaceuticals and other products relevant to pandemic preparedness and response, as well as biotechnology firms, research institutions and academic institutions. Recipients shall select from among the commitments identified in SMTA2 Article 4.1.1(a) to (c) based on their nature and capacities; those that are not manufacturers shall only have to consider contributing to the measures set out in SMTA2 Article 4.1.1(c).

Any manufacturer that enters into any contracts or formal agreements with recipients or GISRS laboratories for the purpose of using PIP Biological Materials on the manufacturer’s behalf for commercialization, public use or regulatory approval of that manufacturer’s vaccines, diagnostics or pharmaceuticals shall also enter into an SMTA2 and select from among the commitments identified in Article 4.1.1(a) to (c) based on their nature and capacities.

¹ See document A72/21 Add.1, see also document WHA72/2019/REC/3, summary records of Committee A, ninth meeting, section 2.

ANNEX 5

Global action plan on promoting the health of refugees and migrants, 2019–2023¹

[A72/25 Rev.1 – 23 May 2019]

[Paragraphs 1–9 set out the background to the global action plan, including the process of its development.]

BRIEF OVERVIEW OF THE GLOBAL SITUATION

10. The number of international migrants² has grown as a proportion of the global population. In 2017, international migrants constituted 3.4% of the global population as compared with 2.8% in 2000. During the period 2000–2017, the total number of international migrants rose from 173 million to 258 million, an increase of 49%.³

11. The Office of the United Nations High Commissioner for Refugees reports that, globally, the number of forcibly displaced people, 68.5 million, is the highest level of human displacement ever;⁴ the figure includes 25.4 million refugees. There are also 10 million stateless people, who lack a nationality and access to basic rights such as education, health care, employment and freedom of movement.

HEALTH CONSEQUENCES AND CHALLENGES

12. Many refugees and migrants lack access to health care services, including health promotion, mental health services (in particular those for post traumatic disorders, which affect many refugees and migrants), disease prevention, treatment and care, as well as financial protection.

13. Nationality should never be a basis for determining access to health care; legal status (often) determines the level of access, as appropriate within national insurance schemes and health systems, without revoking the principle of universal health coverage as set in international agreements. Refugees and migrants may, in some circumstances, fear detection, detention or deportation and may be subject to trafficking or slavery. Unaccompanied children are particularly vulnerable and need specific provisions.

14. Barriers to accessing health care services differ from country to country; they may include language and cultural differences, high costs, discrimination, administrative hurdles, inability to affiliate with local health-financing schemes, adverse living conditions, occupation or blockade of territories and

¹ See decision WHA72(14).

² United Nations, Department of Economic and Social Affairs, Population Division. International migration report 2017. New York: United Nations; 2017. (http://www.un.org/en/development/desa/population/migration/publications/migrationreport/docs/MigrationReport2017_Highlights.pdf, accessed 21 March 2019).

³ United Nations, Department of Economic and Social Affairs, Population Division. Population facts. December 2017 (http://www.un.org/en/development/desa/population/publications/pdf/popfacts/PopFacts_2017-5.pdf, accessed 27 March 2019).

⁴ UNHCR. Figures at a glance (<http://www.unhcr.org/uk/figures-at-a-glance.html>, accessed 21 March 2019).

lack of information about health entitlements. All these conditions make seeking care difficult. Additionally, these experiences can precipitate negative mental health outcomes.

15. Refugees and migrants may come from areas where communicable diseases are endemic. This does not, however, necessarily imply that they are an infectious risk to host and transit populations. They may rather be at risk of contracting communicable diseases, including foodborne and waterborne diseases, as a result of the perils of travelling and factors in the host country associated with poor living and working conditions, together with lack of access to essential health care services. Access to vaccination and continuity of care is more difficult for people on the move. Poor access to medicines and poor management of treatment may facilitate the development of antimicrobial resistance. Specific vulnerabilities to HIV infection and tuberculosis require specific integrated health care services for refugees and migrants.

16. Public health circumstances and obstacles that affect refugees and migrants are specific to both those populations and each phase of the migration and displacement cycle (namely, before and during departure, travel, arrival at destination and possible return). Refugees and migrants with existing chronic conditions and hereditary diseases may experience interruption in their care or episodic care, and they may move without medicines or health records.

17. The migration and displacement process may lead to food insecurity and nutritional problems, including malnutrition (both undernutrition and micronutrient deficiencies). The process also leads to disruption of infant and young child feeding practices and care, and women and children face constraints in accessing essential health care services¹ because of insecurity, gender inequality, cultural discrimination and limited mobility. When food is in short supply, refugee and migrant women and girls in vulnerable situations are more likely than the host population to experience poor nutrition. Pregnant and lactating women are at particular risk of undernutrition owing to their increased physiological requirements.

18. Migrant women and displaced women may have limited access to sexual and reproductive health care services² and may face specific threats to their corresponding rights.³ Many migrant and refugee women do not take up antenatal care or face delays in receiving it because of payment barriers at hospitals, lack of referrals to gynaecologists or fears, including that of being brought to the attention of the authorities and a sense of shame.⁴ International migration results in differences in perinatal outcomes between migrant women and women born in receiving countries and between groups of migrants.⁵ Women are at particular risk of sexual and other forms of gender-based violence, abuse and trafficking. Unaccompanied children are particularly vulnerable and need provision of specific services and care.

¹ Sustainable Development Goal 3, Target 3.8 (achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all).

² Sustainable Development Goal 3, Target 3.7: by 2030 ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes; Sustainable Development Goal 5, Target 5.6: ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

³ In accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conference.

⁴ See, for example: WHO. Women on the Move: migration, care work and health. Geneva: World Health Organization; 2017 (<http://apps.who.int/iris/bitstream/handle/10665/259463/9789241513142-eng.pdf;jsessionid=74E54C79BA2766B73CF7DEE615602CF7?sequence=1>, accessed 21 March 2019).

⁵ European perinatal health report: health and care of pregnant women and babies in Europe in 2010. Paris: EURO-PERISTAT; 2013 (http://europeristat.com/images/doc/EPHR2010_w_disclaimer.pdf, accessed 21 March 2019).

19. Many migrants (and in some cases, refugees), particularly those who are low-skilled and semi-skilled, work in low-paid jobs that are dirty, dangerous and demanding. They often work for longer hours than host-country workers and in unsafe conditions but are less inclined to complain and consequently have worse work-related health outcomes. This is especially the case for migrants and refugees in precarious employment in the informal economy.

20. Several elements link humanitarian crises with disruption of health care services. The health infrastructure may be damaged or destroyed. Health workers may be killed, injured, too distressed to work or displaced, or they may have fled. In crisis-affected environments, health facilities are subject to direct attacks, and health workers may be exposed to physical assault, threats and sexual and gender based violence.¹

ROLES AND RESPONSIBILITIES OF INTERNATIONAL ORGANIZATIONS AND NON STATE ACTORS²

21. Within the United Nations, WHO has a constitutional function to act as the “directing and coordinating authority on international health work”.³ WHO has primary responsibility for promoting and achieving Health for All and universal health coverage within the context of the 2030 Agenda for Sustainable Development and its associated Goals, while leaving no one behind. Additionally, WHO is the health normative agency within the United Nations system; its Thirteenth General Programme of Work, 2019–2023, determines its strategic work, to which this global action plan is aligned.

22. Implementing the global action plan will require the Secretariat to address and manage refugee and migrant health through strongly coordinated work at all levels and in close collaboration with Member States, the International Organization for Migration, the Office of the United Nations High Commissioner for Refugees and other United Nations agencies and networks as well as other international organizations and relevant stakeholders.

23. WHO has collaborated with the International Organization for Migration and the Office of the United Nations High Commissioner for Refugees on several processes to promote the health of refugees and migrants.⁴ In support of collaboration between organizations in the United Nations system, WHO is also a member of the recently established United Nations Network on Migration, for which the International Organization for Migration is the coordinator and secretariat, and whose mandate is to ensure effective United Nations system-wide support for implementation, including the capacity building mechanism, in response to the needs of Member States.

¹ European perinatal health report: health and care of pregnant women and babies in Europe in 2010. Paris: EURO-PERISTAT; 2013 (http://europeperistat.com/images/doc/EPHR2010_w_disclaimer.pdf, accessed 21 March 2019).

² WHO’s Framework of Engagement with Non-State Actors covers nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions.

³ Constitution of the World Health Organization, Article 2(a). Furthermore, the International Covenant on Economic, Social and Cultural Rights (1966), in Articles 2.2 and 12, recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

⁴ See, for example, the first and second global consultations on the health of migrants in 2010 and 2017, respectively; the outcome of the second (High-level meeting of the Global Consultation on Migrant Health, Colombo, 23 February 2017) was the Colombo Statement which was endorsed by participating countries, and resolution CD55.R13 (2016) of the PAHO Directing Council on health of migrants. Furthermore, on 31 January 2019 the International Organization for Migration and WHO signed a Memorandum of Understanding to provide a framework for cooperation and understanding, and to facilitate collaboration between the two Parties.

24. The International Organization for Migration is mandated by its Constitution to further the humane and orderly management of migration, while ensuring effective respect for the human rights of migrants in accordance with international law. It is also mandated to assist in meeting the operational challenges of migration, advancing the understanding of migration issues, encouraging social and economic development through migration, and upholding the human dignity and well-being of migrants. It considers health a core component of all migration or population mobility issues, topics or undertakings.

25. The United Nations General Assembly has mandated the Office of the United Nations High Commissioner for Refugees to provide international protection to refugees and to find durable solutions for their problems, including voluntary repatriation, local integration and voluntary resettlement in third countries. During periods of displacement, it also provides emergency assistance, including health care, as well as clean water, sanitation, shelter, non-food items and sometimes food. The General Assembly has adopted resolutions that have extended its mandate, giving it responsibilities for stateless persons and returnees. In specific situations, and further to a request from the Secretary General or a competent principal organ of the United Nations, the Office provides protection and assistance to internally displaced persons. It considers health to be a core component of refugee protection.

SCOPE

26. The goal of this global action plan is to assert health as an essential component of refugee assistance and good migration governance. The aim of the plan is to improve global health by addressing the health and well-being of refugees and migrants in an inclusive, comprehensive manner and as part of holistic efforts to respond to the health needs of the overall population in any given setting, including the coordination of international efforts to link health care for refugees and migrants to humanitarian programmes. It acknowledges that the entitlement of and access to health services by refugees and migrants vary by country and are determined by national law. Implementation of the plan, once adopted, will take account of specific country situations and be in accordance with national legislation, priorities and circumstances and international instruments on equal access to public health care services.

27. The plan reflects the urgent need for the health sector to deal more effectively with the impact of migration and displacement on health, wherever people have settled. It is fully aligned with the principles set forth and specific references made in WHO's Thirteenth General Programme of Work, 2019–2023.

GUIDING PRINCIPLES

28. The guiding principles for implementation of the global action plan are set out in the framework of priorities and guiding principles to promote the health of refugees and migrants and build on existing instruments and resolutions,¹ for example, the New York Declaration for Refugees and Migrants and resolution WHA70.15 on Promoting the health of refugees and migrants, in which in particular the Health Assembly recalled the need for international cooperation to support countries hosting refugees, and recognizing the efforts of the countries hosting and receiving large populations of refugees and migrants.

¹ For ease of reference the principles are as follows: The right to the enjoyment of the highest attainable standard of physical and mental health; equality and non-discrimination; equitable access to health services; people-centred, refugee-, migrant- and gender-sensitive health systems; non-restrictive health practices based on health conditions; whole-of-government and whole-of-society approaches; participation and social inclusion of refugees and migrants; and partnership and cooperation.

29. In responding to the reality of refugee and migrant movements the plan recommends the following priorities and options for action by the Secretariat in coordination and collaboration with the International Organization for Migration, the Office of the United Nations High Commissioner for Refugees and other relevant partners. These are aligned with the cycle of the Thirteenth General Programme of Work, 2019–2023, and would be implemented in line with nationally expressed needs, national contexts, priorities, legal frameworks and financial situations, with no binding implications for individual Member States.

PRIORITIES OF THE GLOBAL ACTION PLAN

Priority 1. Promote the health of refugees and migrants through a mix of short-term and long-term public health interventions

Objectives

30. To promote the physical and mental health of refugees and migrants by strengthening health care services, as appropriate and acceptable to country contexts and financial situations and in line with their national priorities and legal frameworks and competence, ensuring that essential components, such as vaccination of children and adults and the provision of health promotion, disease prevention, timely diagnosis and treatment, rehabilitation and palliative services for acute, chronic and infectious diseases, injuries, mental and behavioural disorders, and sexual and reproductive health care services for women, are addressed.

Options for the Secretariat in response to requests by Member States include:

- (a) supporting enhanced coordination and collaboration in order to achieve the goal of universal health coverage and the principle of “leaving no one behind” and to develop emergency and humanitarian health responses based on humanitarian principles and the Sendai Framework for Disaster Risk Reduction 2015–2030 and building on WHO’s role as the lead agency for the Inter-Agency Standing Committee Global Health Cluster;
- (b) supporting the preparation of public health responses to refugee and migrant arrivals, while continuing to meet the health needs of the existing migrant and refugee populations and of the receiving population, by ensuring that services for refugees and migrants are delivered through existing health systems to the largest possible extent;
- (c) supporting: diagnostic capacity to detect, and responses to, communicable disease outbreaks, for instance through enhanced surveillance, strategic preparedness and administration of essential vaccines; and access to emergency health services and to medicines and medical products that are safe, effective, affordable, of high quality medicines and available to all – all these activities within comprehensive national health policies and strategies that are aligned with international legal responsibilities and commitments related to the International Health Regulations (2005), with attention to appropriate antibiotic use and prevention of antimicrobial resistance;
- (d) supporting the development of national guidance, models and standards that are designed to underpin the prevention and management of communicable and noncommunicable diseases and mental health conditions: by focusing on risk groups, such as women and girls, unaccompanied and accompanied children, adolescents and youth, older persons, persons with disabilities, those with chronic illnesses, including tuberculosis and HIV infection, survivors of human trafficking, torture, trauma or violence, including sexual and other forms of gender-based

violence; by conducting or strengthening areas including situation assessments, screening, diagnostics, treatment and prevention of gender-based violence; and by addressing risk factors such as tobacco and alcohol use and poor nutrition.

Priority 2. Promote continuity and quality of essential health care, while developing, reinforcing and implementing occupational health and safety measures

Objectives

31. To improve the quality, acceptability, availability and accessibility of health care services, for instance by overcoming physical, financial, information, linguistic and other cultural barriers, with particular attention to services for chronic conditions and mental health, which are often inadequately addressed or followed up during the migration and displacement process, and by working to prevent occupational and work-related diseases and injuries among refugee and migrant workers and their families by improving the coverage, accessibility and quality of occupational and primary health care services and social protection systems, in accordance with Member States' national contexts, priorities and legal frameworks.¹

Options for the Secretariat in response to requests by Member States include:

- (a) supporting the development of quality essential health care services, on a continuing and long-term basis, that are grounded in functioning processes of referral to appropriate secondary and tertiary care services and service-delivery networks for refugees and migrants who require health care services, including access to continuing social and psychological care provision as needed;
- (b) supporting cross-border dialogue and collaboration in order to improve the continuity and quality of care of refugees and migrants, in collaboration with the International Labour Organization, the International Organization for Migration, the Office of the United Nations High Commissioner for Refugees and other relevant partners, and to create uniform protocols for assuring the continuity of care and tracking of patients, thereby reducing loss to follow-up due to the movement of people;
- (c) supporting the development of national action plans and policies, and strengthening institutional capacities for promoting the health of refugee and migrant workers and their families at international forums and in instruments for collaboration and mechanisms of social protection, including the development of tools, policy options, indicators and information materials in line with the provisions of resolution WHA60.26 (2007) on Worker's health: global action plan.

¹ Promotion of the improvement of working conditions is one of the functions of the Organization under Article 2(i) of its Constitution. In resolution WHA60.26 (2007) on Workers' health: global plan of action the Health Assembly urged Member States to devise national policies and plans for implementation of the global plan of action on workers' health and to work towards full coverage of all workers, including inter alia migrant and subcontracted workers, with essential interventions and basic occupational health services for primary prevention of occupational and work-related diseases and injuries.

Priority 3. Advocate the mainstreaming of refugee and migrant health into global, regional and country agendas and the promotion of: refugee-sensitive and migrant sensitive health policies and legal and social protection; the health and well-being of refugee and migrant women, children and adolescents; gender equality and empowerment of refugee and migrant women and girls; and partnerships and intersectoral, intercountry and interagency coordination and collaboration mechanisms

Objectives

32. To help to meet the health needs of refugees and migrants by preventing and mitigating the impact of gender-based inequality in health and access to health services throughout the migration and displacement process by advocating refugees' and migrants' right to the highest attainable standard of physical and mental health, in accordance with international human rights obligations and corresponding relevant international and regional instruments, and by working to lower or remove physical, financial, information and discrimination barriers to accessing health care services in synergy with WHO's partners, including non-State actors.

Options for the Secretariat in response to requests by Member States include:

- (a) supporting the development of strategies, plans and actions designed to strengthen national capacity to meet refugee and migrant health needs and rights, by means that include multisectoral approaches with key stakeholders and facilitation of technical assistance, strategic partnerships and communication;
- (b) supporting the development and implementation of evidence-based public health approaches and the building of health care capacity for service provision, affordable and non-discriminatory access and reduced communication barriers, and training health care providers in culturally-sensitive service delivery and provisions for persons with disabilities;
- (c) supporting ways of ensuring the provision of health care services, aligned with national legislation, including in the areas of sexual and reproductive health and reproductive rights for women, maternal and child health care, prenatal and postnatal care, family planning and provision of access for children in any situation to specific and specialized care and psychological support;
- (d) supporting the development of recommendations and tools for the governance, management and delivery of health care services that address epidemiological factors, cultural and linguistic barriers, and legal, administrative and financial impediments to access, with the involvement of refugee and migrant health workers;
- (e) supporting the identification and strengthening of health care skills within refugee and migrant populations through training and certification, in keeping with national legislation, standards and evaluation;
- (f) supporting existing and as appropriate new global refugee and migration coordination arrangements with Member States, the United Nations, the International Labour Organization, the International Organization for Migration, the Office of the United Nations High Commissioner for Refugees, United Nations Network on Migration, other entities within the United Nations system, and organizations outside the United Nations system, including the International Red Cross and Red Crescent Movement, as well as other humanitarian and development actors, civil society and faith-based organizations;

- (g) providing support for the strengthening of resource mobilization for flexible and multi-year funding to enable countries and communities to respond to the immediate, medium-term and long term health needs of refugees and migrants – in concert with actions to improve the health and well-being of receiving populations and communities and including the health needs of refugees and migrants in existing and new regional and global funding mechanisms;¹
- (h) providing support for establishing or building on existing coordination mechanisms among countries that encourage and allow for exchange of information and implementation of joint actions that help to ensure the continuity of care;
- (i) providing support for the development of intercountry surveillance tools and mechanisms for the exchange of data on the health of refugees and migrants and exchange of information on steps taken and methods used in collecting and analysing data disaggregated by age and gender to inform gender-responsive programmes and services;
- (j) providing support to Member States for promoting optimal health, opportunities for improving health and achieving good health outcomes, especially for young people and women;
- (k) providing support to strengthening the capacity and role of health providers in gender appropriate identification, management and referral of sexual and other forms of gender based violence, such as gender-based discrimination, trafficking, torture and gender-based abuse, as well as in enhanced protection against and prevention of sexual violence and female genital mutilation and in the provision of care and support for the prevention and treatment of sexually transmitted infections and of acute malnutrition;
- (l) providing support to the implementation of the 10 recommendations of the United Nations' High-Level Commission on Health Employment and Economic Growth,² one of which explicitly calls for tackling gender concerns in the health reform process and the health labour market while assuring gender parity in the distribution of health workforces and the elimination of gender-based discrimination within the health workforce.

Priority 4. Enhance capacity to tackle the social determinants of health and to accelerate progress towards achieving the Sustainable Development Goals, including universal health coverage

Objectives

33. To ensure that the social determinants of refugees' and migrants' health are addressed through joint, coherent multisectoral actions in all public health policy responses based on all relevant Sustainable Development Goals, especially Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and Goal 10 (Reduce inequality within and among countries), target 10.7 (Facilitate orderly, safe, and responsible migration and mobility of people, including through implementation of planned and well-managed migration policies).³

¹ The secretariat of the United Nations Network on Migration is establishing a United Nations Network Trust Fund, to be launched imminently.

² See WHO. Working for health and growth: investing in the health workforce. Geneva: World Health Organization; 2016 (<http://www.who.int/iris/handle/10665/250047>, accessed 22 March 2019).

³ Also pertinent is Goal 2 (End hunger, achieve food security and improved nutrition and promote sustainable agriculture).

Options for the Secretariat in response to requests by Member States include:

- (a) supporting, in collaboration with the International Labour Organization, the International Organization for Migration, the Office of the United Nations High Commissioner for Refugees and other relevant partners, the implementation of guidance and assessment tools and the elaboration of country-specific fact sheets and standards in order to highlight and respond to social and economic factors relevant to refugee and migrant health, in the context of universal health coverage and the Sustainable Development Goals and based on partnerships and best practices;
- (b) supporting the identification of relevant sectors and stakeholders that contribute to tackling social determinants of refugee and migrant health and to identifying specific areas for dialogue and joint actions on achieving universal health coverage;
- (c) supporting the training of all personnel working with refugees and migrants on the social determinants of health and necessary policy responses and professional training for health workers, and ensuring that health planners and health care workers are offered support and knowledge-sharing in order to implement appropriate refugee- and migrant-sensitive health interventions that also provide affordable and equitable access to all people;
- (d) strengthening the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel, and reporting thereon.

Priority 5. Strengthen health monitoring and health information systems

Objectives

34. To ensure that information and disaggregated data at global, regional and country levels are generated and that adequate, standardized, comparable records on the health of refugees and migrants are available to support policy-makers and decision-makers to develop more evidence-based policies, plans and interventions.

Options for the Secretariat in response to requests by Member States include:

- (a) supporting work with Member States to develop and implement surveillance of the health of refugees and migrants as part of overall national health surveillance, and issue progress reports that include health-related data on refugees and migrants, disease-risk distribution and risk reduction, in the context of the Sustainable Development Goals, in collaboration and coordination with the International Labour Organization, the International Organization for Migration, the Office of the United Nations High Commissioner for Refugees;
- (b) supporting work with Member States to develop, at country and local levels, disaggregated data on the health of refugees and migrants, including health-seeking behaviour and access to and the use of health care services;
- (c) supporting the development, subject to national contexts and legal frameworks, of intercountry approaches to the generation of data and databases on health risks in countries of origin, transit and destination that can be shared, as well as portable health records and health cards, including the possibility of health cards for population groups in movement, thereby facilitating continuity of care.

Priority 6. Support measures to improve evidence-based health communication and to counter misperceptions about migrant and refugee health**Objectives**

35. To provide accurate information and dispel fears and misperceptions among refugee, migrant and host populations about the health impacts of migration and displacement on refugee and migrant populations and on the health of local communities and health systems.

Options for the Secretariat in response to requests by Member States include:

- (a) supporting the provision of appropriate, factual, timely, culturally-sensitive, user-friendly information on the human rights and health needs of refugees and migrants in order to counter exclusionary acts, such as stigmatization and discrimination;
- (b) supporting advocacy, mass media and public education within the health sector to build support and promote wide participation among government, the public, and other stakeholders;
- (c) supporting the preparation of a global report on the status of refugee and migrant health, in collaboration with the International Labour Organization, the International Organization for Migration, the Office of the United Nations High Commissioner for Refugees;
- (d) supporting the organization, with the International Labour Organization, the International Organization for Migration, the Office of the United Nations High Commissioner for Refugees and other key stakeholders, of a global conference on refugee and migrant health, including the role of the global action plan, which would complement and not duplicate existing forums.

ACTION BY THE HEALTH ASSEMBLY

36. [This paragraph contained one draft decision, which was adopted by the Health Assembly as decision WHA72(14).]

ANNEX 6

Amended Contract of the Director-General¹

[A72/43 Annex – 10 May 2019]

THIS CONTRACT is made this twenty-third day of May of the year two thousand and seventeen between the World Health Organization (hereinafter called the Organization) of the one part and Dr Tedros Adhanom Ghebreyesus (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 twenty-third 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's 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 the Constitution of the World Health Organization; 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. In particular he 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 shall not engage in business or in any employment or activity that would interfere with his duties in the Organization.

¹ See decision WHA72(17), resolution WHA70.3 and document WHA70/2017/REC/1, Annex 1.

(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 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 discretion entirely in respect of representation in connection with his official duties. He 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.

(3) The Director-General shall participate in and contribute to the United Nations Joint Staff Pension Fund in accordance with the Regulations and Rules of the United Nations Joint Staff Pension Fund for the term of his appointment.

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.

.....

Dr Tedros Adhanom Ghebreyesus
Director-General

.....

Professor Veronika Skvortsova
President of the Seventieth
World Health Assembly

ANNEX 7

Examples of the use of gender-specific language in the English version of the Rules of Procedure of the World Health Assembly and amendments¹

[A72/50, Annex – 1 May 2019]

Cases where gender-specific language is used	Examples from the English Version of the Rules of Procedure of the World Health Assembly
	Amended version
“He” (masculine singular pronoun)	The Director-General shall be ex officio Secretary of the Health Assembly and of any subdivision thereof. He or she may delegate these functions. (Rule 16)
“His” (masculine singular possessive pronoun)	In plenary meetings the chief delegate may designate another delegate who shall have the right to speak and vote in the name of her or his delegation on any question. (Rule 19)
“Him” (masculine singular objective pronoun)	Moreover, upon the request of the chief delegate or any delegate so designated by her or him the President may allow an adviser to speak on any particular point. (Rule 19)
“Chairman” and “vice-chairman” (masculine singular nouns)	The chair of a main committee shall, in the case of absence, designate a vice-chair of the committee as her or his substitute, provided that this vice-chair shall not have the right to vote if he or she is of the same delegation as another member of the General Committee. ... (Rule 29)
“Chairmen” (masculine plural noun)	The Chairs of these main committees shall be elected by the Health Assembly. (Rule 32)
“Vice-Chairmen” (masculine plural noun)	Each main committee shall elect two Vice-Chairs and a Rapporteur. (Rule 34)
“Himself” (masculine singular reflexive pronoun)	Thus, within the scope of the Rules of Procedure, delegates or representatives are enabled to direct the attention of the presiding officer to violations or misapplications of the Rules by other delegates or representatives or by the presiding officer herself or himself. (Description of the Concept of a Point of Order) ^a

^a Adopted as a supplement to the Rules of Procedure of the World Health Assembly through resolution WHA29.37 (1976).

¹ See decision WHA72(21).

ANNEX 8

Text of amended Rules of Procedure of the World Health Assembly¹

[A72/51, Annex – 13 May 2019,
A72/52, Annex – 16 May 2019]

Preparation of the agenda of the Health Assembly by the Executive Board (decision WHA72(22))

Rule 5

The Board shall include on the provisional agenda of each regular session of the Health Assembly inter alia:

- (a) the annual report of the Director-General on the work of the Organization;
- (b) all items that the Health Assembly has, in a previous session, ordered to be included;
- (c) any items pertaining to the budget for the next financial period and to reports on the accounts for the preceding year or period;
- (d) any item proposed by a Member or by an Associate Member;
- (e) subject to such preliminary consultation as may be necessary between the Director-General and the Secretary-General of the United Nations, any item proposed by the United Nations;
- (f) any item proposed by any other organization of the United Nations system with which the Organization has entered into effective relations.

The Board may recommend to the World Health Assembly the deferral of any item under (d), (e) and (f) above.

Any proposal for inclusion on the provisional agenda of any item under (d), (e) and (f) above shall be accompanied by an explanatory memorandum that shall reach the Director-General no later than four weeks before the commencement of the session of the Board at which the provisional agenda of the Health Assembly is to be prepared.

.....

Rule 11

Unless the Health Assembly decides otherwise in case of urgency, proposals for new activities to be undertaken by the Organization may be placed upon the supplementary agenda of any session only if such proposals are received at least six weeks before the date of the opening of the session, or if the proposal is one which should be referred to another organ of the Organization for examination with a view to deciding whether action by the Organization is desirable. Any such proposal shall be accompanied by an explanatory memorandum.

.....

¹ See decisions WHA72(22) and WHA72(23).

Rule 12

Subject to the provisions of Rule 11 regarding new activities and to the provisions of Rule 96, a supplementary item may be added to the agenda during any session, if upon the report of the General Committee the Health Assembly so decides, provided that the request for the inclusion of the supplementary item reaches the Organization no later than six days prior to the opening of a regular session or no later than two days prior to the opening of a special session. Any such request shall be accompanied by an explanatory memorandum.

.....
Time limits for tabling draft resolutions and/or decisions to the Health Assembly (decision WHA72(22))

Rule 48

Formal proposals relating to items of the agenda should be introduced at least fifteen days before the opening of a regular session of the Health Assembly and may, in any event, be introduced not later than the first day of a regular session of the Health Assembly and no later than two days before the opening of a special session. All such proposals shall be referred to the committee to which the item of the agenda has been allocated, except if the item is considered directly in a plenary meeting.

.....
Alignment of the terminology used in the Rules of Procedure of the World Health Assembly with that used in the Framework of Engagement with Non-State Actors (decision WHA72(22))

Electronic submission of credentials (decision WHA72(23))

Note: Whenever any of the following terms appear in these Rules, reference shall be as indicated below:

“Constitution – to the Constitution of the World Health Organization”

“Organization” – to the World Health Organization

“Health Assembly” – to the World Health Assembly

“Board” – to the Executive Board

“Members” – to Members of the World Health Organization

“Associate Members” – to Associate Members of the World Health Organization

“Financial period” – to a period of two consecutive calendar years beginning with an even-numbered year.

“Official relations” – to a privilege that the Executive Board may grant to nongovernmental organizations, international business associations and philanthropic foundations in accordance with the Framework of Engagement with Non-State Actors.

.....

Rule 3

Notices convening a regular session of the Health Assembly shall be sent by the Director-General not less than sixty days and notices convening a special session not less than thirty days before the date fixed for the opening of the session, to Members and Associate Members, to representatives of the Board and to all participating intergovernmental organizations and nongovernmental organizations, international business associations and philanthropic foundations in official relations with the Organization^a invited to be represented at the session. The Director-General may invite States having made application for membership, territories on whose behalf application for associate membership has been made, and States which have signed but not accepted the Constitution to send observers to sessions of the Health Assembly.

.....

Rule 14

Copies of all reports and other documents relating to the provisional agenda of any session shall be made available on the Internet and sent by the Director-General to Members and Associate Members and to participating intergovernmental organizations at the same time as the provisional agenda or not less than six weeks before the commencement of a regular session of the Health Assembly; appropriate reports and documents shall also be sent to nongovernmental organizations, international business associations and philanthropic foundations in official relations with the Organization in the same manner.

.....

Rule 19

Plenary meetings of the Health Assembly will, unless the Health Assembly decides otherwise, be open to attendance by all delegates, alternates and advisers appointed by Members, in accordance with Articles 10–12 inclusive of the Constitution, by representatives of Associate Members appointed in accordance with Article 8 of the Constitution, and the resolution governing the status of Associate Members, by representatives of the Board, by observers of invited non-Member States and territories on whose behalf application for associate membership has been made, and also by invited representatives of the United Nations and of other participating intergovernmental organizations and nongovernmental organizations, international business associations and philanthropic foundations in official relations.

In plenary meetings the chief delegate may designate another delegate who shall have the right to speak and vote in the name of his delegation on any question. Moreover, upon the request of the chief delegate or any delegate so designated by him the President may allow an adviser to speak on any particular point, but the latter shall not vote in the name of his delegation on any question.

.....

Rule 22

Each Member, Associate Member, participating intergovernmental organization and nongovernmental organization, international business association and philanthropic foundation in official relations shall communicate to the Director-General, if possible not less than fifteen days before the opening of the Health Assembly, the names of its representatives. In the case of delegations of Members and Associate Members, such communications shall take the form of credentials, indicating the names of its delegates, alternates and advisers, and shall be issued by the Head of State, the Head of Government, the Minister for Foreign Affairs, the Minister of Health or by any other appropriate authority. Such credentials may be sent electronically or hand-delivered to the Director-General.

.....

Rule 23

A Committee on Credentials consisting of representatives of twelve Members shall be appointed at the beginning of each session by the Health Assembly on the proposal of the President. This committee shall elect its own officers. It shall assess whether the credentials of Members and Associate Members are in conformity with the requirements of the Rules of Procedure and report to the Health Assembly without delay. Pending a decision by the Health Assembly on their credentials, representatives of Members and Associate Members shall be seated provisionally with all the rights pertaining to their participation in the Health Assembly. The President shall be empowered to recommend to the Health Assembly the acceptance of credentials received after the Committee on Credentials has met.

Meetings of the Committee on Credentials shall be held in private.

.....

Heading between Rule 43 and Rule 44

PARTICIPATION OF REPRESENTATIVES OF ASSOCIATE MEMBERS,
INTERGOVERNMENTAL ORGANIZATIONS, NON-STATE ACTORS IN OFFICIAL
RELATIONS, AND OBSERVERS OF NON-MEMBER STATES AND TERRITORIES

.....

Rule 47

Representatives of nongovernmental organizations, international business associations and philanthropic foundations in official relations may be invited to attend plenary meetings and meetings of the main committees of the Health Assembly and to participate without vote therein in accordance with the Framework of Engagement with Non-State Actors, when invited to do so by the President of the Health Assembly or by the chairman of a main committee, respectively.

.....

Motion to suspend the debate (decision WHA72(23))*Rule 59*

During the discussion of any matter, a delegate or a representative of an Associate Member may move the suspension or the adjournment of the meeting or the suspension of the debate. Such motions shall not be debated, but shall immediately be put to a vote.

For the purpose of these Rules “suspension of the meeting” means the temporary postponement of the business of the meeting, “adjournment of the meeting” the termination of all business until another meeting is called, and “suspension of the debate” the postponement of further discussion on the matter under discussion until later in the same session.

.....

Electronic voting for recorded votes (decision WHA72(23))*Rule 72*

The Health Assembly shall normally vote by show of hands, except that any delegate may request a recorded vote. Where an appropriate electronic system is available, the Health Assembly may decide to conduct any vote under this rule by electronic means.

.....

Rule 72 bis

When the Health Assembly conducts a recorded vote without using electronic means, the vote shall be conducted by roll-call, which shall be taken in the English or French alphabetical order of the names of the Members. The name of the Member to vote first shall be determined by lot.

.....

Rule 73

The vote of each Member participating in a recorded vote shall be inserted in the record of the meeting.

.....

ANNEX 9

Financial and administrative implications for the Secretariat of resolutions and decisions adopted by the Health Assembly

Resolution WHA72.2	Primary health care
A. Link to the approved Programme budget 2018–2019	
1. Output(s) in the approved Programme budget 2018–2019 to which this resolution will contribute:	4.2.1. Equitable integrated, people-centred service delivery systems in place in countries and public health approaches strengthened
2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2018–2019:	Not applicable.
3. Any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the approved Programme budget 2018–2019:	Not applicable.
4. Estimated implementation time frame (in years or months) to achieve the resolution:	11 years: one year preparatory phase in 2019 plus 10 years (five bienniums, during the period 2019–2029).
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	US\$ 376.5 million (expansion to regions and countries for 2018–2019 only to be confirmed at a later date).
2.a. Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US\$ millions:	US\$ 1.8 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2018–2019, in US\$ millions:	Not applicable.
3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:	US\$ 54.0 million.
4. Estimated resource requirements in future programme budgets, in US\$ millions:	US\$ 320.7 million.
5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions	
– Resources available to fund the resolution in the current biennium:	US\$ 1.6 million.

- **Remaining financing gap in the current biennium:**
US\$ 0.2 million.
- **Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:**
Not applicable.

Table. Breakdown of estimated resource requirements (in US\$ millions)

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2018–2019 resources already planned	Staff	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2
	Activities	0.0	0.0	0.0	0.0	0.0	0.0	1.6	1.6
	Total	0.0	0.0	0.0	0.0	0.0	0.0	1.8	1.8
2018–2019 additional resources	Staff	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Activities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
2020–2021 resources to be planned	Staff	10.6	3.0	2.3	2.1	4.4	2.0	2.2	26.6
	Activities	8.0	3.0	3.0	3.0	4.0	3.2	3.2	27.4
	Total	18.6	6.0	5.3	5.1	8.4	5.2	5.4	54.0
Future bienniums resources to be planned	Staff	62.4	20.5	23.0	13.5	25.6	18.6	10.0	173.6
	Activities	40.1	16.1	20.1	16.1	20.1	20.1	14.5	147.1
	Total	102.5	36.6	43.1	29.6	45.7	38.7	24.5	320.7

Resolution WHA72.3	Community health workers delivering primary health care: opportunities and challenges
A. Link to the approved Programme budget 2018–2019	
1. Output(s) in the approved Programme budget 2018–2019 to which this resolution will contribute:	Output 4.2.2. Health workforce strategies oriented towards universal health coverage implemented in countries
2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2018–2019:	Not applicable.
3. Any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the approved Programme budget 2018–2019:	Not applicable.
4. Estimated implementation time frame (in years or months) to achieve the resolution:	60 months.

B. Resource implications for the Secretariat for implementation of the resolution
1. Total resource requirements to implement the resolution, in US\$ millions: US\$ 11.62 million, as part of the delivery of integrated human resources for health programming
2.a. Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US\$ millions: US\$ 2.28 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2018–2019, in US\$ millions: Not applicable.
3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions: US\$ 4.58 million.
4. Estimated resource requirements in future programme budgets, in US\$ millions: US\$ 4.76 million.
5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions
– Resources available to fund the resolution in the current biennium: US\$ 2.28 million.
– Remaining financing gap in the current biennium: Not applicable.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium: Not applicable.

Table. Breakdown of estimated resource requirements (in US\$ millions)

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2018–2019 resources already planned	Staff	0.20	0.10	0.11	0.03	0.12	0.13	0.24	0.93
	Activities	0.39	0.14	0.17	0.05	0.11	0.21	0.28	1.35
	Total	0.59	0.24	0.28	0.08	0.23	0.34	0.52	2.28
2018–2019 additional resources	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2020–2021 resources to be planned	Staff	0.39	0.21	0.22	0.06	0.25	0.26	0.47	1.86
	Activities	0.78	0.29	0.34	0.10	0.23	0.43	0.55	2.72
	Total	1.17	0.50	0.56	0.16	0.48	0.69	1.02	4.58
Future bienniums resources to be planned	Staff	0.41	0.22	0.23	0.06	0.26	0.27	0.49	1.94
	Activities	0.81	0.30	0.36	0.10	0.24	0.44	0.57	2.82
	Total	1.22	0.52	0.59	0.16	0.50	0.71	1.06	4.76

Resolution WHA72.4	Preparation for the high-level meeting of the United Nations General Assembly on universal health coverage
A. Link to the approved Programme budget 2018–2019	
1. Output(s) in the approved Programme budget 2018–2019 to which this resolution will contribute:	<p>4.2.1 Equitable integrated, people-centred service delivery systems in place in countries and public health approaches strengthened.</p> <p>4.3.1 Access to and use of essential medicines and other health technologies improved through global guidance and the development and implementation of national policies, strategies and tools.</p> <p>4.4.1 Comprehensive monitoring of the global, regional and country health situation, trends, inequalities and determinants, using global standards, including data collection and analysis to address data gaps and system performance assessment.</p>
2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2018–2019:	Not applicable.
3. Any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the approved Programme budget 2018–2019:	Not applicable.
4. Estimated implementation time frame (in years or months) to achieve the resolution:	12 years (covering the period 2019–2030)
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	US\$ 435.9 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US\$ millions:	US\$ 26.0 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2018–2019, in US\$ millions:	Zero.
3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:	US\$ 59.6 million.
4. Estimated resource requirements in future programme budgets, in US\$ millions:	US\$ 350.3 million.

- 5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions**
- **Resources available to fund the resolution in the current biennium:**
US\$ 1.0 million
 - **Remaining financing gap in the current biennium:**
US\$ 25.0 million
 - **Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:**
Zero.

Table. Breakdown of estimated resource requirements (in US\$ millions)

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2018–2019 resources already planned	Staff	1.7	0.8	1.3	1.0	1.5	1.2	5.8	13.3
	Activities	2.7	0.9	1.6	1.5	1.3	1.4	3.3	12.7
	Total	4.4	1.7	2.9	2.5	2.8	2.6	9.1	26.0
2018–2019 additional resources	Staff	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Activities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
2020–2021 resources to be planned	Staff	3.8	1.9	2.9	2.3	3.3	2.8	13.3	30.3
	Activities	6.3	2.2	3.7	3.3	3.1	3.2	7.5	29.3
	Total	10.1	4.1	6.6	5.6	6.4	6.0	20.8	59.6
Future bienniums resources to be planned	Staff	22.6	11.2	17.1	13.6	19.6	16.6	78.0	178.7
	Activities	36.8	12.7	21.7	19.6	18.1	18.8	43.9	171.6
	Total	59.4	23.9	38.8	33.2	37.7	35.4	121.9	350.3

Resolution WHA72.5 Antimicrobial resistance

A. Link to the approved Programme budget 2018–2019

1. Output(s) in the approved Programme budget 2018–2019 to which this resolution will contribute:

1.6.1. All countries have essential capacity to implement national action plans to monitor, prevent and reduce infections caused by antimicrobial resistance

1.6.2. Appropriate use and availability of antimicrobial medicines in human health and food production settings as a contribution to improving access to and maintaining effectiveness of treatment

1.6.3. High-level political commitment sustained and effective coordination at the global level to combat antimicrobial resistance in support of the Sustainable Development Goals

2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2018–2019:

Not applicable.

<p>3. Any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the approved Programme budget 2018–2019:</p> <p>The resolution requests the Director-General to accelerate the implementation of the global action plan on antimicrobial resistance across all levels of WHO, and significantly enhance support and technical assistance to countries to implement their multisectoral national action plans for combating antimicrobial resistance.</p>
<p>4. Estimated implementation time frame (in years or months) to achieve the resolution:</p> <p>Three years: 2019–2021.</p>
<p>B. Resource implications for the Secretariat for implementation of the resolution</p>
<p>1. Total resource requirements to implement the resolution, in US\$ millions:</p> <p>US\$ 124.4 million.</p>
<p>2.a. Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US\$ millions:</p> <p>US\$ 41.7 million.</p>
<p>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2018–2019, in US\$ millions.</p> <p>An additional US\$ 10 million for 2019.</p>
<p>3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:</p> <p>US\$72.7 million.</p> <p>The estimated resource requirements are based on planned country costs, regional costs and headquarters costs for the biennium, including the scale-up of capacity to provide technical assistance to implement the resolution.</p>
<p>4. Estimated resource requirements in future programme budgets, in US\$ millions:</p> <p>Not applicable</p>
<p>5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions</p> <ul style="list-style-type: none"> – Resources available to fund the resolution in the current biennium: US\$ 38 million. – Remaining financing gap in the current biennium: US\$ 13.7 million. – Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium: US\$ 8 million in 2019, based on current projections.

Table. Breakdown of estimated resource requirements (in US\$ millions)

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2018–2019 resources already planned	Staff	2.3	0.0	4.5	2.5	1.8	2.7	12.9	26.7
	Activities	4.5	1.6	1.0	2.2	0.8	0.8	4.1	15.0
	Total	6.8	1.6	5.5	4.7	2.6	3.5	17.0	41.7
2018–2019 additional resources	Staff	0.5	0.5	0.5	0.5	0.5	0.5	2.0	5.0
	Activities	0.5	1.0	0.5	0.5	0.5	0.5	1.5	5.0
	Total	1.0	1.5	1.0	1.0	1.0	1.0	3.5	10.0
2020–2021 resources to be planned	Staff	2.5	4.2	3.3	1.8	1.5	2.2	16.0	31.5
	Activities	8.4	6.0	5.6	2.3	4.0	3.2	11.7	41.2
	Total	10.9	10.2	8.9	4.1	5.5	5.4	27.7	72.7
Future bienniums resources to be planned	Staff	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Activities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Resolution WHA72.6	Global action on patient safety
A. Link to the approved Programme budget 2018–2019	
1. Output(s) in the approved Programme budget 2018–2019 to which this resolution will contribute:	4.2.3. Countries enabled to improve patient safety and quality of services, and patient empowerment within the context of universal health coverage
2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2018–2019:	Not applicable.
3. Any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the approved Programme budget 2018–2019:	Not applicable.
4. Estimated implementation time frame (in years or months) to achieve the resolution:	Seven years (covering the period 2019–2025) (2019 + 3 additional bienniums).
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	US\$ 39.37 million (6 years).
2.a. Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US\$ millions:	US\$ 3.86 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2018–2019, in US\$ millions:	Zero.
3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:	US\$ 12.16 million.

4. Estimated resource requirements in future programme budgets, in US\$ millions: US\$ 23.35 million (2022–2025).
5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions
– Resources available to fund the resolution in the current biennium: US\$ 1.48 million.
– Remaining financing gap in the current biennium: US\$ 2.38 million.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium: Fundraising ongoing.

Table. Breakdown of estimated resource requirements (in US\$ millions)

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2018–2019 resources already planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	1.00	1.00
	Activities	0.42	0.08	0.22	0.21	0.26	0.21	1.46	2.86
	Total	0.42	0.08	0.22	0.21	0.26	0.21	2.46	3.86
2018–2019 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 resources to be planned	Staff	1.01	0.20	0.52	0.52	0.62	0.51	2.21	5.59
	Activities	1.52	0.29	0.79	0.78	0.94	0.77	1.48	6.57
	Total	2.53	0.49	1.31	1.30	1.56	1.28	3.69	12.16
Future bienniums (2022–2025) resources to be planned	Staff	1.95	0.38	1.01	0.99	1.20	0.98	4.25	10.76
	Activities	2.92	0.57	1.51	1.49	1.80	1.47	2.83	12.59
	Total	4.87	0.95	2.52	2.48	3.00	2.45	7.08	23.35

Resolution WHA72.7 Water, sanitation and hygiene in health care facilities
A. Link to the approved Programme budget 2018–2019
1. Output(s) in the approved Programme budget 2018–2019 to which this resolution will contribute:
3.5.1. Country capacity enhanced to assess health risks and to develop and implement policies, strategies or regulations for the prevention, mitigation and management of the health impacts of environmental and occupational risks
3.1.1. Countries enabled to improve maternal health through further expansion of access to, and improvement in the quality of, effective interventions for ending preventable maternal deaths from pre-pregnancy to postpartum and perinatal deaths (stillbirths and early neonatal deaths) with a particular focus on the 24-hour period around childbirth
4.2.3. Countries enabled to improve patient safety and quality of services, and patient empowerment within the context of universal health coverage

<p>2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2018–2019: Not applicable.</p>
<p>3. Any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the approved Programme budget 2018–2019: Not applicable.</p>
<p>4. Estimated implementation time frame (in years or months) to achieve the resolution: Six years in total. Implementation in one country takes about two years; implementation can be carried out in parallel in several countries.</p>
<p>B. Resource implications for the Secretariat for implementation of the resolution</p>
<p>1. Total resource requirements to implement the resolution, in US\$ millions: US\$ 9.83 million over six years (up to mid-2025).</p>
<p>2.a. Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US\$ millions: US\$ 2.71 million.</p> <p>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2018–2019, in US\$ millions: Not applicable.</p>
<p>3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions: US\$ 3.56 million.</p>
<p>4. Estimated resource requirements in future programme budgets, in US\$ millions: US\$ 3.56 million.</p>
<p>5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions</p> <ul style="list-style-type: none"> – Resources available to fund the resolution in the current biennium: US\$ 2.71 million. – Remaining financing gap in the current biennium: Not applicable. – Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium: Not applicable.

Table. Breakdown of estimated resource requirements (in US\$ millions)

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2018–2019 resources already planned	Staff	0.22	0.05	0.20	0.07	0.05	0.19	1.16	1.94
	Activities	0.11	0.01	0.05	0.03	0.01	0.05	0.51	0.77
	Total	0.33	0.06	0.25	0.10	0.06	0.24	1.67	2.71
2018–2019 additional resources	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2020–2021 resources to be planned	Staff	0.63	0.05	0.16	0.07	0.06	0.19	1.20	2.36
	Activities	0.14	0.04	0.08	0.04	0.02	0.10	0.78	1.20
	Total	0.77	0.09	0.24	0.11	0.08	0.29	1.98	3.56
Future bienniums resources to be planned	Staff	0.63	0.05	0.16	0.07	0.06	0.19	1.20	2.36
	Activities	0.14	0.04	0.08	0.04	0.02	0.10	0.78	1.20
	Total	0.77	0.09	0.24	0.11	0.08	0.29	1.98	3.56

Resolution WHA72.8	Improving the transparency of markets for medicines, vaccines, and other health products
A. Link to the approved Programme budget 2018–2019	
1. Output(s) in the approved Programme budget 2018–2019 to which this resolution will contribute:	4.3.1. Access to and use of essential medicines and other health technologies improved through global guidance and the development and implementation of national policies, strategies and tools
2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2018–2019:	Not applicable.
3. Any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the approved Programme budget 2018–2019:	Not applicable.
4. Estimated implementation time frame (in years or months) to achieve the resolution:	4.5 years, aligned with the Thirteenth General Programme of Work, 2019–2023.
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	US\$ 3 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US\$ millions:	US\$ 0.5 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2018–2019, in US\$ millions:	Not applicable.

3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions: US\$ 1.5 million.
4. Estimated resource requirements in future programme budgets, in US\$ millions: US\$ 1 million.
5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions <ul style="list-style-type: none"> – Resources available to fund the resolution in the current biennium: US\$ 0.25 million. – Remaining financing gap in the current biennium: US\$ 0.25 million. – Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium: Not applicable.

Table. Breakdown of estimated resource requirements (in US\$ millions)

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2018–2019 resources already planned	Staff	–	–	–	–	–	–	0.5	0.5
	Activities	–	–	–	–	–	–	0.0	0.0
	Total	–	–	–	–	–	–	0.5	0.5
2018–2019 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 resources to be planned	Staff	–	–	–	–	–	–	1.0	1.0
	Activities	–	–	–	–	–	–	0.5	0.5
	Total	–	–	–	–	–	–	1.5	1.5
Future bienniums resources to be planned	Staff	–	–	–	–	–	–	0.7	0.7
	Activities	–	–	–	–	–	–	0.3	0.3
	Total	–	–	–	–	–	–	1.0	1.0

Resolution WHA72.13 Salaries of staff in ungraded positions and of the Director-General**A. Link to the approved Programme budget 2018–2019**

- 1. Output(s) in the approved Programme budget 2018–2019 to which this resolution will contribute:**
Outcome 6.4. Effective and efficient management and administration consistently established across the Organization
Output 6.4.2. Effective and efficient human resources management and coordination in place

- 2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2018–2019:**

Not applicable.

<p>3. Any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the approved Programme budget 2018–2019:</p> <p>Not applicable.</p>
<p>4. Estimated implementation time frame (in years or months) to achieve the resolution:</p> <p>The relevant adjustments in remuneration took effect from 1 January 2019.</p> <p>There is no defined end date for implementation.</p>
<p>B. Resource implications for the Secretariat for implementation of the resolution</p>
<p>1. Total resource requirements to implement the resolution, in US\$ millions:</p> <p>The resource requirements are already included within what is planned under the approved Programme budget 2018–2019.</p> <p>Regarding modifications to staff salaries, it should be noted that payroll costs are always subject to some variability due to post adjustment, exchange rates, staff mix in terms of dependency and education grant entitlements, among other factors. Thus these additional costs will be absorbed within the overall payroll budget fluctuations.</p>
<p>2.a. Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US\$ millions:</p> <p>Not applicable.</p>
<p>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2018–2019, in US\$ millions:</p> <p>Not applicable.</p>
<p>3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:</p> <p>Not applicable.</p>
<p>4. Estimated resource requirements in future programme budgets, in US\$ millions:</p> <p>Not applicable.</p>
<p>5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions</p> <ul style="list-style-type: none"> – Resources available to fund the resolution in the current biennium: Not applicable. – Remaining financing gap in the current biennium: Not applicable. – Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium: Not applicable.

<p>Resolution WHA72.15 Eleventh revision of the International Classification of Diseases</p>
<p>A. Link to the approved Programme budget 2018–2019</p>
<p>1. Output(s) in the approved Programme budget 2018–2019 to which this resolution will contribute:</p> <p>4.4.1. Comprehensive monitoring of the global, regional and country health situation, trends, inequalities and determinants using global standards, including data collection and analysis to address data gaps and system performance assessment</p>

2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2018–2019:
Not applicable.
3. Any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the approved Programme budget 2018–2019:
Not applicable.
4. Estimated implementation time frame (in years or months) to achieve the resolution:
The ICD-11 would be considered for adoption at the Seventy-second World Health Assembly in May 2019.
B. Resource implications for the Secretariat for implementation of the resolution
1. Total resource requirements to implement the resolution, in US\$ millions:
US\$ 3.65 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US\$ millions:
US\$ 3.65 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2018–2019, in US\$ millions:
Not applicable. There are no supplementary resource requirements, because ICD-related work has always been part of WHO's core activities and mandate.
3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:
Not applicable.
4. Estimated resource requirements in future programme budgets, in US\$ millions:
Not applicable.
5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions
– Resources available to fund the resolution in the current biennium:
US\$ 3.65 million.
– Remaining financing gap in the current biennium:
Not applicable.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:
Not applicable.

Table. Breakdown of estimated resource requirements (in US\$ millions)

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2018–2019 resources already planned	Staff	–	–	–	–	–	–	1.90	1.90
	Activities	–	–	–	–	–	–	1.75	1.75
	Total	–	–	–	–	–	–	3.65	3.65

Resolution WHA72.16	Emergency care systems for universal health coverage: ensuring timely care for the acutely ill and injured
A. Link to the approved Programme budget 2018–2019	
1. Output(s) in the approved Programme budget 2018–2019 to which this resolution will contribute:	<p>2.3.1. Development and implementation of multisectoral plans and programmes to prevent injuries, with a focus on achieving the targets set under the Decade of Action for Road Safety (2011–2020)</p> <p>2.3.4. Improved pre-hospital and facility-based emergency care systems to address injury</p> <p>4.2.1. Equitable integrated, people-centred service delivery systems in place in countries and public health approaches strengthened</p>
2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2018–2019:	Not applicable.
3. Any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the approved Programme budget 2018–2019:	Not applicable.
4. Estimated implementation time frame (in years or months) to achieve the resolution:	Five years.
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	US\$ 25.69 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US\$ millions:	US\$ 0.34 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2018–2019, in US\$ millions:	Zero.
3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:	US\$ 12.67 million.
4. Estimated resource requirements in future programme budgets, in US\$ millions:	US\$ 12.67 million.
5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions	<ul style="list-style-type: none"> – Resources available to fund the resolution in the current biennium: US\$ 0.34 million. – Remaining financing gap in the current biennium: Zero. – Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium: Not applicable.

Table. Breakdown of estimated resource requirements (in US\$ millions)^a

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2018–2019 resources already planned	Staff	–	–	–	–	–	–	0.25	0.25
	Activities	–	–	–	–	–	–	0.09	0.09
	Total	–	–	–	–	–	–	0.34	0.34
2018–2019 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 resources to be planned	Staff	2.86	1.50	0.85	1.19	1.14	1.25	1.39	10.17
	Activities	0.36	0.36	0.36	0.36	0.36	0.36	0.36	2.50
	Total	3.21	1.86	1.21	1.55	1.50	1.61	1.74	12.67
Future bienniums resources to be planned	Staff	2.86	1.50	0.85	1.19	1.14	1.25	1.39	10.17
	Activities	0.36	0.36	0.36	0.36	0.36	0.36	0.36	2.50
	Total	3.21	1.86	1.21	1.55	1.50	1.61	1.74	12.67

^a The row and column totals may not always add up, due to rounding.

Decision WHA72(8)	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan
A. Link to the approved Programme budget 2018–2019	
1. Output(s) in the approved Programme budget 2018–2019 to which this decision will contribute:	<p>6.1.1. Effective WHO leadership and management and improved capacities of the WHO Secretariat and Member States to promote, align, coordinate and operationalize efforts to achieve the Sustainable Development Goals</p> <p>6.1.2. Effective engagement with other United Nations agencies and non-State actors in building a common health agenda that responds to Member States' priorities</p> <p>6.4.1. Sound financial practices managed through an adequate control framework</p> <p>6.4.2. Effective and efficient human resources management and coordination in place</p> <p>6.4.3. Efficient and effective computing infrastructure, corporate and health-related systems and applications</p> <p>6.4.4. Provision of operational and logistics support, procurement, infrastructure maintenance and asset management, and of a secure environment for WHO staff and property</p> <p>Outbreak and crisis response</p>
2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2018–2019:	Not applicable.
3. Any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the approved Programme budget 2018–2019:	Not applicable.
4. Estimated implementation time frame (in years or months) to achieve the decision:	One year: June 2019–May 2020.

Decision WHA72(11) Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases
A. Link to the approved Programme budget 2018–2019
<p>1. Output(s) in the approved Programme budget 2018–2019 to which this decision will contribute:</p> <p>2.1.1. Development and implementation of national multisectoral policies and plans to prevent and control noncommunicable diseases accelerated</p> <p>2.1.2. Countries enabled to implement strategies to reduce modifiable risk factors for noncommunicable diseases (tobacco use, diet, physical inactivity and harmful use of alcohol), including the underlying social determinants</p> <p>2.1.3. Countries enabled to improve health care coverage for the management of cardiovascular diseases, cancer, diabetes and chronic respiratory diseases and their risk factors, including in crises and emergencies</p>
<p>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2018–2019:</p> <p>Not applicable.</p>
<p>3. Any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the approved Programme budget 2018–2019:</p> <p>Not applicable.</p>
<p>4. Estimated implementation time frame (in years or months) to achieve the decision:</p> <p>Seven years. All activities referred to in the draft decision will be carried out from 2019 during the bienniums 2018–2019, 2020–2021, 2022–2023 and 2024–2025 until the fourth high-level meeting of the General Assembly on the prevention and control of non-communicable diseases in 2025.</p>
B. Resource implications for the Secretariat for implementation of the decision
<p>1. Total resource requirements to implement the decision, in US\$ millions:</p> <p>US\$ 602 million (2019–2025).</p>
<p>2.a. Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US\$ millions:</p> <p>US\$ 86 million.</p>
<p>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2018–2019, in US\$ millions:</p> <p>Not applicable.</p>
<p>3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:</p> <p>US\$ 172 million.</p>
<p>4. Estimated resource requirements in future programme budgets, in US\$ millions:</p> <p>US\$ 344 million.</p>
<p>5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions</p> <ul style="list-style-type: none"> – Resources available to fund the decision in the current biennium: US\$ 10 million (12% of US\$ 86 million) at the time of writing. – Remaining financing gap in the current biennium: US\$ 76 million (88% of US\$ 86 million).

- **Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:**

US\$ 76 million – the amount is increasing on a rolling basis throughout the biennium, based on continuous resource-mobilization efforts.

Table. Breakdown of estimated resource requirements (in US\$ millions)

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2018–2019 resources already planned	Staff	11.5	5.5	5.5	5.5	5.5	5.5	18.0	57.0
	Activities	5.5	3.0	3.0	3.0	3.0	3.0	8.5	29.0
	Total	17.0	8.5	8.5	8.5	8.5	8.5	26.5	86.0
2018–2019 additional resources	Staff	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Activities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
2020–2021 resources to be planned	Staff	23.0	11.0	11.0	11.0	11.0	11.0	36.0	114.0
	Activities	11.0	6.0	6.0	6.0	6.0	6.0	17.0	58.0
	Total	34.0	17.0	17.0	17.0	17.0	17.0	53.0	172.0
Future bienniums resources to be planned	Staff	46.0	22.0	22.0	22.0	22.0	22.0	72.0	228.0
	Activities	22.0	12.0	12.0	12.0	12.0	12.0	34.0	116.0
	Total	68.0	34.0	34.0	34.0	34.0	34.0	106.0	344.0

Decision WHA72(12) Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits
A. Link to the approved Programme budget 2018–2019
1. Output(s) in the approved Programme budget 2018–2019 to which this decision will contribute: Not applicable.
2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2018–2019: The Pandemic Influenza Preparedness (PIP) Framework operates outside the Programme budget. The current decision follows from decision WHA71(11) (2018). The PIP Framework is expected to operate inside the programme budget for 2020–2021.
3. Any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the approved Programme budget 2018–2019: The Secretariat plans to develop an approach to provide support to countries in adopting access and benefit-sharing legislation and other measures that support public health.
4. Estimated implementation time frame (in years or months) to achieve the decision: One year, with a report on progress to the Seventy-third World Health Assembly through the Executive Board at its 146th session.
B. Resource implications for the Secretariat for implementation of the decision
1. Total resource requirements to implement the decision, in US\$: US\$ 722 950 Staff costs (US\$ 622 950) + activity costs (US\$ 100 000)

2.a. Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US\$:
Not applicable.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2018–2019, in US\$:
US\$ 722 950
3. Estimated resource requirements in the Programme budget 2020–2021, in US\$:
Not applicable.
4. Estimated resource requirements in future programme budgets, in US\$:
Not applicable.
5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$
– Resources available to fund the decision in the current biennium:
US\$ 502 100
– Remaining financing gap in the current biennium:
US\$ 220 850
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:
Not yet known.

Decision WHA72(13)	The public health implications of implementation of the Nagoya Protocol
A. Link to the approved Programme budget 2018–2019	
1. Output(s) in the approved Programme budget 2018–2019 to which this decision will contribute:	E.1.1. Control strategies, plans and capacities developed for diseases such as cholera, viral haemorrhagic fever, meningitis and influenza and those due to vector-borne, emerging and re-emerging pathogens E.1.2. Global expert networks and innovative mechanisms developed to manage new and evolving high-threat infectious hazards (such as for clinical management, laboratories, social science, and data modelling)
2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2018–2019:	Not applicable.
3. Any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the approved Programme budget 2018–2019:	Not applicable.
4. Estimated implementation time frame (in years or months) to achieve the decision:	30 months.
B. Resource implications for the Secretariat for implementation of the decision	
1. Total resource requirements to implement the decision, in US\$ millions:	US\$ 1.02 million.

Decision WHA72(19) 2020: International Year of the Nurse and the Midwife	
A. Link to the approved Programme budget 2018–2019	
1. Output(s) in the approved Programme budget 2018–2019 to which this decision will contribute:	4.2.2. Health workforce strategies oriented towards universal health coverage implemented in countries
2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2018–2019:	Not applicable.
3. Any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the approved Programme budget 2018–2019:	Not applicable.
4. Estimated implementation time frame (in years or months) to achieve the decision:	12 months.
B. Resource implications for the Secretariat for implementation of the decision	
1. Total resource requirements to implement the decision, in US\$ millions:	US\$ 2.2 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US\$ millions:	US\$ 0.6 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2018–2019, in US\$ millions:	Not applicable.
3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:	US\$ 1.6 million.
4. Estimated resource requirements in future programme budgets, in US\$ millions:	Not applicable.
5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions	
– Resources available to fund the decision in the current biennium:	US\$ 0.6 million.
– Remaining financing gap in the current biennium:	Not applicable.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:	Not applicable.

Table. Breakdown of estimated resource requirements (in US\$ millions)

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2018–2019 resources already planned	Staff	–	–	–	–	–	–	0.5	0.5
	Activities	–	–	–	–	–	–	0.1	0.1
	Total	–	–	–	–	–	–	0.6	0.6
2018–2019 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	0.1	0.1	0.1	0.1	0.1	0.1	1.0	1.6
	Total	0.1	0.1	0.1	0.1	0.1	0.1	1.0	1.6
Future bienniums resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–

Decision WHA72(20) World Chagas Disease Day
A. Link to the approved Programme budget 2018–2019
1. Output(s) in the approved Programme budget 2018–2019 to which this decision will contribute: 1.4.1. Implementation and monitoring of the WHO roadmap for neglected tropical diseases facilitated 1.4.3. New knowledge, solutions and implementation strategies that respond to the health needs of disease-endemic countries developed through strengthened research and training
2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2018–2019: Not applicable.
3. Any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the approved Programme budget 2018–2019: Not applicable.
4. Estimated implementation time frame (in years or months) to achieve the decision: One year.
B. Resource implications for the Secretariat for implementation of the decision
1. Total resource requirements to implement the decision, in US\$ millions: US\$ 0.2 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US\$ millions: US\$ 0.1 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2018–2019, in US\$ millions: Zero.

3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:
US\$ 0.1 million.
4. Estimated resource requirements in future programme budgets, in US\$ millions:
Zero.
5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions
– Resources available to fund the decision in the current biennium:
US\$ 0.05 million.
– Remaining financing gap in the current biennium:
US\$ 0.05 million.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:
An additional US\$ 0.05 million is anticipated from various partners.

Table. Breakdown of estimated resource requirements (in US\$ millions)

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2018–2019 resources already planned	Staff	–	–	–	–	–	–	0.02	0.02
	Activities	–	0.05	–	0.015	–	0.015	–	0.08
	Total	–	0.05	–	0.015	–	0.015	0.02	0.10
2018–2019 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 resources to be planned	Staff	–	–	–	–	–	–	0.02	0.02
	Activities	–	0.05	–	0.015	–	0.015	–	0.08
	Total	–	0.05	–	0.015	–	0.015	0.02	0.10
Future bienniums resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–

Decision WHA72(21) WHO reform: amendments to the Rules of Procedure of the World Health Assembly (replacing or supplementing gender-specific language)

A. Link to the approved Programme budget 2018–2019

1. Output(s) in the approved Programme budget 2018–2019 to which this decision will contribute:

6.1.3. WHO governance strengthened with effective oversight of governing body sessions and efficient, aligned agendas

6.5.1. Accurate and timely health information accessible through a platform for effective communication and related practices

2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2018–2019:

Not applicable.

<p>3. Any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the approved Programme budget 2018–2019:</p> <p>Not applicable.</p>
<p>4. Estimated implementation time frame (in years or months) to achieve the decision:</p> <p>Option 1: None, as no change to current practice.</p> <p>Option 2: Up to 12 months following the closure of the Seventy-second World Health Assembly/ 145th session of the Board (to produce the next edition of <i>Basic documents</i>).</p> <p>Option 3: Three months (to prepare the amended Rules of Procedure of the governing bodies for submission to the 145th session of the Board).</p>
<p>B. Resource implications for the Secretariat for implementation of the decision</p>
<p>1. Total resource requirements to implement the decision, in US\$ millions:</p> <p>Option 1: None, as no change would be required.</p> <p>Option 2: US\$ 0.06 million, for the production of the next edition of <i>Basic documents</i>. The costs of updating the Rules of Procedure of the governing bodies in <i>Basic documents</i> would be subsumed in the costs of the planned production of the next edition. The costs of the production of the next edition are outlined in sections B2 to B5.</p> <p>Option 3: None, as updating the Rules of Procedure of the governing bodies for consideration by the 145th session of the Board would be covered within the context of a document being submitted to the governing bodies and thus as core work.</p>
<p>Sections B2 to B5 refer only to Option 2</p> <p>2.a. Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US\$ millions:</p> <p>US\$ 0.03 million.</p> <p>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2018–2019, in US\$ millions:</p> <p>Not applicable.</p>
<p>3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:</p> <p>US\$ 0.03 million.</p>
<p>4. Estimated resource requirements in future programme budgets, in US\$ millions:</p> <p>Not applicable.</p>
<p>5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions</p> <p>– Resources available to fund the decision in the current biennium:</p> <p>US\$ 0.03 million.</p> <p>– Remaining financing gap in the current biennium:</p> <p>Not applicable.</p> <p>– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</p> <p>Not applicable.</p>

Decision WHA72(22)	WHO reform: amendments to the Rules of Procedure of the World Health Assembly (report of the Executive Board Chairperson on the outcome of the informal consultation on governance reform)
A. Link to the approved Programme budget 2018–2019	
1. Output(s) in the approved Programme budget 2018–2019 to which this decision will contribute:	6.1.3. WHO governance strengthened with effective oversight of governing body sessions and efficient, aligned agendas.
2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2018–2019:	Not applicable.
3. Any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the approved Programme budget 2018–2019:	Not applicable.
4. Estimated implementation time frame (in years or months) to achieve the decision:	11 months.
B. Resource implications for the Secretariat for implementation of the decision	
1. Total resource requirements to implement the decision, in US\$ millions:	US\$ 0.08 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US\$ millions:	US\$ 0.08 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2018–2019, in US\$ millions:	Zero.
3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:	Zero.
4. Estimated resource requirements in future programme budgets, in US\$ millions:	Zero.
5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions	
– Resources available to fund the decision in the current biennium:	US\$ 0.08 million.
– Remaining financing gap in the current biennium:	Zero.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:	Not applicable.

Table. Breakdown of estimated resource requirements (in US\$ millions)

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2018–2019 resources already planned	Staff	–	–	–	–	–	–	0.02	0.02
	Activities	–	–	–	–	–	–	0.06	0.06
	Total	–	–	–	–	–	–	0.08	0.08