EB144/2019/REC/1

WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD

144TH SESSION

GENEVA, 24 JANUARY–1 FEBRUARY 2019

RESOLUTIONS AND DECISIONS
ANNEXES

GENEVA
2019

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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

PREFACE

The 144th session of the Executive Board was held at WHO headquarters, Geneva, from 24 January to 1 February 2019. The proceedings are issued in two volumes. The present volume contains the resolutions and decisions, and relevant annexes. The summary records of the Board's discussions, and details regarding membership of committees, are issued in document EB144/2019/REC/2. The list of participants and officers is contained in document EB144/DIV./1 Rev.1.

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[1] As adopted by the Board at its first meeting (24 January 2019).

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RESOLUTIONS

EB144.R1 Appointment of the Regional Director for South-East Asia

The Executive Board,

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

Considering also the nomination made by the Regional Committee for South-East Asia at its seventy-first session,

1. REAPPOINTS Dr Poonam Khetrapal Singh as Regional Director for South-East Asia as from 1 February 2019;

2. AUTHORIZES the Director-General to issue a contract to Dr Poonam Khetrapal Singh for a period of five years from 1 February 2019, subject to the provisions of the Staff Regulations and Staff Rules.

(Fifth meeting, 26 January 2019)

EB144.R2 Appointment of the Regional Director for the Western Pacific

The Executive Board,

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

Considering also the nomination made by the Regional Committee for the Western Pacific at its sixty-ninth session,

1. APPOINTS Dr Takeshi Kasai as Regional Director for the Western Pacific as from 1 February 2019;

2. AUTHORIZES the Director-General to issue a contract to Dr Takeshi Kasai for a period of five years from 1 February 2019, subject to the provisions of the Staff Regulations and Staff Rules.

(Fifth meeting, 26 January 2019)

EB144.R3 Expression of appreciation to Dr Shin Young-soo

The Executive Board,

Desiring on the occasion of the retirement of Dr Shin Young-soo as Regional Director for the Western Pacific to express its appreciation for his services to the World Health Organization;

Mindful of Dr Shin Young-soo’s lifelong, professional devotion to the cause of international health, and recalling especially his 10 years of service as Regional Director for the Western Pacific;

Recalling resolution WPR/RC69.R9, adopted by the Regional Committee for the Western Pacific, which designates Dr Shin Young-soo as Regional Director Emeritus,

1. EXPRESSES its profound gratitude and appreciation to Dr Shin Young-soo for his invaluable and longstanding contribution to the work of WHO;

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

(Fifth meeting, 26 January 2019)

EB144.R4 Community health workers delivering primary health care: opportunities and challenges[1]

The Executive Board,

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]

RECOMMENDS to the Seventy-second World Health Assembly the adoption of the following resolution:

The Seventy-second World Health Assembly,

Inspired by the ambition of the 2030 Agenda for Sustainable Development, with its vision to leave no one behind, its 17 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

[1] See Annex 7 for the financial and administrative implications for the Secretariat of this resolution.

[2] Document EB144/13.

[3] WHO guideline on health policy and system support to optimize community health worker programmes. Geneva: World Health Organization; 2018. Available at http://www.who.int/hrh/community/guideline-health-support-optimize-hw-programmes/en/ (accessed 6 February 2019).

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;

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 WHO's Global Strategy on Human Resources for Health: Workforce 2030, with the Global Strategy identifying the opportunity 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 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 (Astana, 25 and 26 October 2018) through which participating governments reaffirmed 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 investments 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 youth, 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 to accelerate 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 services, 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 to contribute 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;

2. URGES all Member States,[1] 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:[2]

(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

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

[2] Taking into account the context of federated States where health is a shared responsibility between national and subnational authorities.

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 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 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 the 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 to support 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 its 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 both information exchange and technical cooperation and implementation research between Member States and relevant stakeholders – including South–South cooperation – 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 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 and resolution WHA70.6 (2017) 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 global strategy on human resources for health: workforce 2030.

(Eighth meeting, 28 January 2019)

EB144.R5 Water, sanitation and hygiene in health care facilities[1]

The Executive Board,

Having considered the report on patient safety: water, sanitation and hygiene in health care facilities,[2]

RECOMMENDS to the Seventy-second World Health Assembly the adoption of the following resolution:

The Seventy-second World Health Assembly,

Recalling the Declaration of Astana from the Global Conference on Primary Health Care (Astana, 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 effective 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

[1] See Annex 7 for the financial and administrative implications for the Secretariat of this resolution.

[2] Document EB144/30.

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) 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 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 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 WHA68.7 (2015) on the global action plan on antimicrobial resistance, which underscores 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, *Water, sanitation and hygiene in health care facilities: status in low- and middle-income countries and way forward*,[1] which revealed that close to 40% of all health care facilities globally lack access to even rudimentary water supplies, 19% lack sanitation and 35% do not have water and soap for handwashing,[2] 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 making a global call for action for water, sanitation and hygiene in all health care facilities;

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[1] WHO and UNICEF. Water, sanitation and hygiene in health care facilities: status in low- and middle-income countries and way forward. Geneva: World Health Organization; 2015.

[2] WHO and UNICEF will release Sustainable Development Goal baseline figures for safe water, sanitation and hygiene (WASH) in health care facilities in March/April 2019. These new figures will supersede the figures currently stated in the resolution.

Noting that the Director-General's report to the Seventy-first World Health Assembly on health, environment and climate change[1] 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:[2]

(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 regional and global protocols or tools[3,4] and in collaboration with the global effort to improve provision of safe water, sanitation and hygiene in health care facilities;[5]

(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 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 control[6] into national monitoring mechanisms to establish baselines, track progress, and track health system performance on a regular basis;

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[1] Document A71/11.

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

[3] 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/UNICEF; 2018 (https://www.who.int/water_sanitation_health/publications/water-and-sanitation-for-health-facility-improvement-tool/en/, accessed 7 February 2019).

[4] 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).

[5] 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.washinhcf.org (accessed 7 February 2019).

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

(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 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 facilities[1] 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);

(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 a sufficient 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 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;

[1] WHO/UNICEF global activities on WASH in health care facilities. (https://www.who.int/water_sanitation_health/facilities/en/, accessed 7 February 2019).

(2) to support government 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 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 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 established indicator reporting methodology for Sustainable Development Goal 6 (Ensure availability and sustainable management of water and sanitation for all);[1]

(7) to support coordination and implementation 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.

(Thirteenth meeting, 30 January 2019)

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

EB144.R6 Scale of assessments for 2020–2021

The Executive Board,

Having considered the report on the scale of assessments for 2020–2021,[1]

RECOMMENDS to the Seventy-second World Health Assembly the adoption of the following resolution:

The Seventy-second World Health Assembly,

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

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
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

[1] Document EB144/44.

Members and Associate Members	WHO scale for 2020–2021 %
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
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

Members and Associate Members	WHO scale for 2020–2021 %
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
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

Members and Associate Members	WHO scale for 2020–2021 %
New Zealand	0.2910
Nicaragua	0.0050
Niger	0.0020
Nigeria	0.2500
Niue (not a member of the United Nations)	0.0010
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
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

Members and Associate Members	WHO scale for 2020–2021 %
Switzerland	1.1511
Syrian Arab Republic	0.0110
Tajikistan	0.0040
Thailand	0.3070
The former Yugoslav Republic of Macedonia	0.0070
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
Venezuela (Bolivarian Republic of)	0.7280
Viet Nam	0.0770
Yemen	0.0100
Zambia	0.0090
Zimbabwe	0.0050
Total	**100.0000**

(Fifteenth meeting, 31 January 2019)

EB144.R7 Confirmation of amendments to the Staff Rules: salaries of staff in the professional and higher categories[1]

The Executive Board,

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

[1] See Annex 1, and Annex 7 for the financial and administrative implications for the Secretariat of this resolution.

[2] Document EB144/49 Rev.1.

CONFIRMS, in accordance with Staff Regulation 12.2, the amendments to the Staff Rules that have been made by the Director-General with effect from 1 January 2019 concerning the remuneration of staff in the professional and higher categories and concerning a common scale of staff assessment.

(Fifteenth meeting, 31 January 2019)

EB144.R8 Confirmation of amendments to the Staff Rules: salaries of staff in ungraded positions and of the Director-General[1]

The Executive Board,

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

RECOMMENDS to the Seventy-second World Health Assembly the adoption of the following resolution:

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,

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.

(Fifteenth meeting, 31 January 2019)

EB144.R9 Primary health care[3]

The Executive Board,

Having considered the report on universal health coverage: primary health care towards universal health coverage,[4]

RECOMMENDS to the Seventy-second World Health Assembly the adoption of the following resolution:

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[1] See Annex 1, and Annex 7 for the financial and administrative implications for the Secretariat of this resolution.

[2] Document EB144/49 Rev.1.

[3] See Annex 7 for the financial and administrative implications for the Secretariat of this resolution.

[4] Document EB144/12.

The Seventy-second World Health Assembly,

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, 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;

2. URGES Member States[1] to take measures to 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 Member States, 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 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 the institutional capacity

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

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;

(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.

(Seventeenth meeting, 1 February 2019)

EB144.R10 Preparation for the high-level meeting of the United Nations General Assembly on universal health coverage[1]

The Executive Board,

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]

RECOMMENDS to the Seventy-second World Health Assembly the adoption of the following resolution:

The Seventy-second World Health Assembly,

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 in September 2015, Heads of State and Government 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 committed to ensuring, by 2030, universal access to sexual and reproductive health care services, including for family planning,

[1] See Annex 7 for the financial and administrative implications for the Secretariat of this resolution.

[2] Document EB144/14.

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 emphasises 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, and 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 create an enabling environment at all levels for sustainable development in the spirit of global partnership and solidarity, and 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 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 one billion more people benefitting from universal health coverage, one billion more people better protected from health emergencies, as well as further contributing to one 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, which committed 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 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 of 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 other health-related Sustainable Development Goals and targets, as envisioned in the Declaration of Astana from 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, as well as 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 the 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 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 other 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;

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

(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;

(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 the 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 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 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 to encourage 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 advocacy and for 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).

(Seventeenth meeting, 1 February 2019)

EB144.R11 Antimicrobial resistance[1]

The Executive Board,

Having considered the report on antimicrobial resistance,[2]

RECOMMENDS to the Seventy-second World Health Assembly the adoption of the following resolution:

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;

Recalling 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 address antimicrobial resistance through a coordinated, multisectoral, One Health approach;

[1] See Annex 7 for the financial and administrative implications for the Secretariat of this resolution.

[2] Document EB144/19.

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;

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, including vaccination, and other infection prevention and control measures, such as adequate water, sanitation and hygiene (WASH), in reducing antimicrobial resistance;

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

Recalling FAO resolution 4/2015 on antimicrobial resistance, World Organisation for Animal Health (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;

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

(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 address 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;

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

(7) to develop or strengthen 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 the national action plans;

(8) to enhance cooperation at all levels for concrete action towards combatting 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 multi-stakeholder collaboration to develop and apply tools to address 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 the 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 work streams, and 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 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;

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[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.

(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, through the Executive Board, incorporating this work into existing antimicrobial resistance reporting, in order to allow Member States to review and evaluate efforts made.

(Seventeenth meeting, 1 February 2019)

EB144.R12 Global action on patient safety[1]

The Executive Board,

Having considered the report on global action on patient safety,[2]

RECOMMENDS to the Seventy-second World Health Assembly the adoption of the following resolution:

The Seventy-second World Health Assembly,

Having considered the report by the Director-General on global action on patient safety;

Recalling resolution WHA55.18 (2002), 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 ensures 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 further the importance of hygiene for patient safety and the prevention of health care-associated infections, and for reducing antimicrobial resistance;

Noting 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 and the need to promote and improve patient safety across health systems at all levels, sectors and

[1] See Annex 7 for the financial and administrative implications for the Secretariat of this resolution.

[2] Document EB144/29.

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 requires 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, and places a considerable strain on health system finances and 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, and in implementing safety and quality programmes, initiatives and interventions, such as insurance arrangements, patient ombudspersons, creating a patient safety culture throughout the health system, transparent incident reporting systems that allow learning from mistakes, and no-fault and no-blame handling of adverse events and their consequences; and 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 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;

(3) to develop and implement national policies, legislation, strategies, guidance and tools and deploy adequate resources, in order to strengthen 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, for example, 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

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

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;

(13) to mark World Patient Safety Day annually on 17 September 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 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 States[1] and all relevant stakeholders, including in the private sector, for submission to the Seventy-fourth World Health Assembly in 2021 through the 148th session of the Executive Board;

(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.

(Seventeenth meeting, 1 February 2019)

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

DECISIONS

EB144(1) 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[1]

The Executive Board, 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,[2] describing the outcomes of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, decided to recommend to the Seventy-second World Health Assembly the adoption of the following decision:

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, describing the outcomes of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, decided:

(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 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,[3] 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

[1] See Annex 7 for the financial and administrative implications for the Secretariat of this decision.

[2] Document EB144/20.

[3] In accordance with WHO's Framework of Engagement with Non-State Actors.

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 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, 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

[1] Including those requested in: resolution WHA53.17 (2000) on prevention and control of noncommunicable diseases; resolution WHA57.17 (2004) on global strategy on diet, physical activity and health; resolution WHA63.13 (2010) on global strategy to reduce the harmful use of alcohol; resolution WHA65.6 (2012) on comprehensive implementation plan on maternal, infant and young child nutrition; resolution WHA66.8 (2013) on comprehensive mental health action plan 2013–2020; resolution WHA66.10 (2013) on 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 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 global action plan on the public health response to dementia; decision WHA70(19) (2017) on report of the Commission on Ending Childhood Obesity: implementation plan; resolution WHA71.6 (2018) on WHO 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.

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 voluntary innovative funding mechanisms, such as a multi-donor trust fund, building on ongoing relevant work.

(Eleventh meeting, 30 January 2019)

EB144(2) Accelerating the elimination of cervical cancer as a global public health problem[1]

The Executive Board, having considered the report on accelerating cervical cancer elimination,[2] decided:

(1) to note that urgent action is needed to scale up implementation of proven cost-effective measures towards achieving the elimination of cervical cancer as a global public health problem, including vaccination against human papillomavirus, screening and treatment of pre-cancer, early detection and prompt treatment of early invasive cancers, and palliative care, which will require political commitment and greater international cooperation and support for equitable access, including strategies for resource mobilization;

(2) to request the Director-General to develop, in consultation with Member States and other relevant stakeholders, a draft global strategy to accelerate cervical cancer elimination, with clear goals and targets for the period 2020–2030, for consideration by the Seventy-third World Health Assembly, through the Executive Board at its 146th session.

(Thirteenth meeting, 30 January 2019)

[1] See Annex 7 for the financial and administrative implications for the Secretariat of this decision.

[2] Document EB144/28.

EB144(3) WHO reform processes, including the transformation agenda, and implementation of United Nations development system reform[1]

The Executive Board, having considered the report of the Executive Board Chairperson on the outcome of the informal consultation on governance reform,[2] decided:

(1) to amend Rule 4 of the Rules of Procedure of the Executive Board as set out in the Chairperson's summary and proposed way forward[3] following the informal consultation on governance reform, with effect from the closure of the 144th session of the Executive Board;

(2) to amend Rule 28bis of the Rules of Procedure of the Executive Board as set out in the Chairperson's summary and proposed way forward following the informal consultation on governance reform, with effect from the closure of the 144th session of the Executive Board;

(3) to request the Director-General to elaborate a report and make recommendations to be submitted to the Executive Board at its 145th session about an informal meeting or forum to bring together Member States and non-State actors in official relations with WHO;

(4) to recommend to the Seventy-second World Health Assembly in 2019 the adoption of the following decision:

The Seventy-second World Health Assembly decided:

(1) to amend Rules 5, 11, and 12 of the Rules of Procedure of the World Health Assembly as set out in the Chairperson's summary and proposed way forward[2] following the informal consultation on governance reform, 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 the Chairperson's summary and proposed way forward following the informal consultation on governance reform, 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 the Chairperson's summary and proposed way forward following the informal consultation on governance reform, 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;

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[1] See Annex 2, and Annex 7 for the financial and administrative implications for the Secretariat of this decision.

[2] Document EB144/34.

[3] Document EB144/34, Annex.

(5) to request the Director-General:

(a) to provide Member States with a template for the explanatory memorandum referred to in the third paragraph of Rule 5 of the Rules of Procedure of the World Health Assembly, as amended in time for consideration of proposed additional items by the Executive Board at its 146th session;

(b) to issue an updated edition of *Basic documents* following the closure of the Seventy-second World Health Assembly in May 2019;

(c) to submit to the Executive Board, at its 145th session in May 2019, draft guidelines for Member States, to be applied before posting a written statement on the dedicated website;

(d) to align the duration of publication on the website of written statements submitted by Member States with those submitted by non-State actors in official relations with WHO;

(e) with respect to the methods of work of the World Health Assembly and the Executive Board, to undertake the following steps:

(i) review and make recommendations on the establishment of end dates for reporting on resolutions and decisions that have unspecified reporting requirements;

(ii) review and make recommendations on consolidating and managing reporting requirements on similar subjects;

(iii) continue to take steps towards consolidating reports on similar subjects within existing mandates;

(iv) advise Member States, when submitting proposals for resolutions or decisions, on the length of the reporting cycle and on whether the proposed reporting requirements could be aligned with the reporting timelines of resolutions or decisions on related subjects;

(v) provide a list of global strategies and action plans, highlighting in particular the ones that will expire during the timeline of the Thirteenth General Programme of Work, 2019–2023, and outline options for their extension, as appropriate;

(vi) organize an informal consultation with Member States prior to the 146th session of the Executive Board (January 2020) to present the recommendations referred to in subparagraphs (i) and (ii)and list mentioned in subparagraph (v) above;

(vii) submit a report to the Executive Board at its 146th session on the steps outlined in subparagraphs (i)–(vi) above;

(f) to update on a regular basis the forward-looking schedule of agenda items for the World Health Assembly and Executive Board, taking into account priorities set out in the general programme of work.

(Fourteenth meeting, 31 January 2019)

EB144(4) WHO reform processes, including the transformation agenda, and implementation of United Nations development system reform[1]

The Executive Board, having considered the report by the Director-General on WHO reform processes, including the transformation agenda, and implementation of United Nations development system reform: WHO reform,[2] decided:

(1) to amend its Rules of Procedure in line with the examples set out in the Annex to document EB144/33[3] 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;

(2) that the amendments shall come into effect at the moment when the Director-General renumbers the Rules of Procedure of the Executive Board of the World Health Organization in accordance with decision EB143(7) (2018);

(3) to recommend that the Seventy-second World Health Assembly:

(i) amend its Rules of Procedure in line with the examples set out in the Annex to document EB144/33 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;

(ii) decide 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, and subject to the adoption by the Health Assembly of, the draft decision recommended by the Board in decision EB143(7) (2018).

(Fourteenth meeting, 31 January 2019)

EB144(5) Engagement with non-State actors[1,4]

The Executive Board, having examined the report on engagement with non-State actors: non-State actors in official relations with WHO, including the review of one third of the non-State actors in official relations with WHO,[5]

[1] See Annex 7 for the financial and administrative implications for the Secretariat of this decision.

[2] Document EB144/33.

[3] See also Annex 3.

[4] See Annex 4.

[5] Document EB144/37.

(1) decided:

(a) to admit into official relations with WHO the following non-State actors: The Albert B. Sabin Vaccine Institute, Inc., The International League of Dermatological Societies, The Royal National Lifeboat Institution, The Task Force for Global Health, United Nations Foundation, Inc., Women Deliver, Inc. and World Federation of Nuclear Medicine and Biology;

(b) to discontinue official relations with the following non-State actors: International Catholic Committee of Nurses and Medico-Social Assistants, International Eye Foundation, International Organization for Standardization and International Union of Microbiological Societies;

(2) noted with appreciation the collaboration with WHO of the 71 non-State actors listed in Annex 2 to document EB144/37, commended their continuing contribution to the work of WHO, and decided to renew them in official relations with WHO;

(3) further noted that plans for collaboration with the following entities have yet to be agreed, and decided to defer the review of relations with Commonwealth Pharmacists Association, CropLife International, Global Health Council and Save the Children until the 146th session of the Board in January 2020, at which time reports should be presented to the Board on the agreed plans for collaboration and on the status of relations.

(Fourteenth meeting, 31 January 2019)

EB144(6) Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits[1]

The Executive Board, having considered the report contained in document EB144/23 on implementation of decision WHA71(11) (2018)[2] decided to recommend to the Seventy-second World Health Assembly the adoption of the following decision:

[The Seventy-second World Health Assembly, having considered the report **contained in document EB144/23 [EU]** on implementation of decision WHA71(11) (2018), decided:

OP (1) consistent with the PIP Advisory Group's recommendations to the Director-General,[3] to request the Director-General:

(a) to urgently work with the Global Influenza Surveillance and Response System and other partners to **identify and [EU]** address the challenges and uncertainties related to the sharing of seasonal influenza viruses that have emerged as countries implement the Nagoya Protocol;

(b) to closely monitor instances where **influenza virus sharing is affected, including due to the** implementation of the Nagoya Protocol **[EU] OR** to closely monitor instances where influenza virus sharing is affected, including due to **countries' domestic measures in implementing** the Nagoya Protocol **[USA]**

[1] See Annex 7 for the financial and administrative implications for the Secretariat of this decision.

[2] Document EB144/23.

[3] Meeting of the Pandemic Influenza Preparedness Framework Advisory Group. 17–19 October 2018, Geneva, Switzerland. Geneva: World Health Organization; 2018 (http://www.who.int/influenza/pip/AGMR_Oct2018.pdf?ua=1, accessed 3 December 2018).

and/or for other reasons, and to present findings thereon to the next meeting of the PIP Advisory Group. [EU] ~~may be affecting the sharing of seasonal influenza viruses and collect, analyse and present data on virus sharing in time for the next Advisory Group meeting, to allow a deeper understanding of potential problems that exist with influenza virus sharing~~; **[EU] and to share these findings with the WHO's broader effort referenced below regarding the public health implications of the Nagoya Protocol; [USA]**

(c) to assess the ~~utility~~ **usefulness [EU]** of the prototype search engine developed to identify products that ~~potentially~~ **[EU]** have made use of genetic sequence data of influenza viruses with pandemic potential ~~and have not been subject to the benefit-sharing system~~; **[EU]**

(d) to explore **in consultation with Member States [USA]** ~~the~~ **[EU]** possible next steps in ~~implementing the principle of acknowledgment of the contributions of data providers and active collaboration between~~ **raising awareness of the PIP Framework among databases and initiatives, [EU]** data providers and **data [EU]** users~~.~~**, and to present such possible steps to the next meeting of the PIP Advisory Group. [EU]** ~~In particular, the Director-General is requested to develop appropriate language for consideration by relevant databases to inform potential users of genetic sequence data of influenza viruses with pandemic potential about the PIP Framework.~~ **[EU]**

OP (2) **to work quickly with Member States and relevant stakeholders to explore and evaluate approaches to address concerns regarding the issues raised in paragraph 23 to EB144/23 [USA]** ~~to amend footnote 1 in the Standard Material Transfer Agreement 2, in Annex 2 to the PIP Framework,[1] as set out in the report of the Director-General on implementation of decision WHA71(11) (2018),[2] with effect from the closure of the Seventy-second World Health Assembly, in order to address a loophole that has arisen in connection with indirect uses of PIP biological materials by companies with the result that they do not provide fair and equitable benefit sharing for the use of PIP biological materials~~; **[USA]**

OP (3) to work collaboratively across WHO to raise awareness among Member States of the implications for public health of implementation of the Nagoya Protocol, particularly given the cross-cutting nature of relevant issues: [EU]

OP (~~3~~ **4**) **[EU]** to further request the Director-General to report on progress to implement the foregoing to the Seventy-third World Health Assembly in 2020 through the 146th session of the Executive Board.

[1] Pandemic influenza preparedness framework for the sharing of influenza viruses and access to vaccines and other benefits. Geneva: World Health Organization; 2011 (http://www.who.int/influenza/resources/pip_framework/en/, accessed 3 December 2018).

[2] The relevant document for consideration by the Seventy-second World Health Assembly in 2019 will reflect the amendments to footnote 1 in Annex 2 to the PIP Framework contained in the Annex to document EB144/23.

ANNEX

PROPOSED AMENDMENT TO FOOTNOTE 1 OF ANNEX 2 OF THE PIP FRAMEWORK[1]

Current version	Proposed amended version
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. Each recipient shall select options based on its nature and capacities.	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 PIP Biological Materials 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.

(Fourteenth meeting, 31 January 2019)

EB144(7) Provisional agenda of the Seventy-second World Health Assembly

The Executive Board, having considered the report of the Director-General on the provisional agenda of the Seventy-second World Health Assembly,[2] and recalling its earlier decision that the Seventy-second World Health Assembly should be held at the Palais des Nations in Geneva, opening on Monday, 20 May 2019, and closing no later than Tuesday, 28 May 2019,[3] approved the provisional agenda of the Seventy-second World Health Assembly.

(Seventeenth meeting, 1 February 2019)

EB144(8) Date and place of the 145th session of the Executive Board

The Executive Board decided that its 145th session should be convened on 29 and 30 May 2019, at WHO headquarters, Geneva.

(Seventeenth meeting, 1 February 2019)

EB144(9) Establishment of the Nelson Mandela Award for Health Promotion

The Executive Board, having considered the proposal contained in document EB144/40 Add.1, decided to establish the Nelson Mandela Award for Health Promotion and to approve the draft statutes annexed thereto, as well as the proposed streamlined measures to be applied for bestowing the first Nelson Mandela Award for Health Promotion in 2019.

(Seventeenth meeting, 1 February 2019)

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[1] Proposed new text is shown in bold.

[2] Document EB144/41 Rev.1

[3] See decision EB143(5) (2018).

EB144(10) Award of the Dr A.T. Shousha Foundation Prize and Fellowship

The Executive Board, having considered the report of the Dr A.T. Shousha Foundation Committee,[1] awarded the Dr A.T. Shousha Foundation Prize for 2019 to Dr Radi Hammad, Director-General of the Viral Hepatitis Control Department at the Ministry of Health and Population of Egypt, for his significant contribution to public health in Egypt. The laureate will receive the equivalent of 2500 Swiss francs in United States dollars.

The Executive Board, awarded the Dr A.T. Shousha Fellowship for 2019 to Ms Golaleh Asghari to enable her to study for a PhD in nutrition sciences. Ms Asghari has demonstrated a desire to make a significant original contribution to research in nutrition and to find new methods for translating research and evidence into policy, programmes and practice, pursuant to her long-term goal of a career in teaching and research. The laureate will receive US$ 15,000.

(Seventeenth meeting, 1 February 2019)

EB144(11) Award of the Sasakawa Health Prize

The Executive Board, having considered the report of the Sasakawa Health Prize Selection Panel,[2] awarded the Sasakawa Health Prize for 2019 to Professor Judith Ndongo Embola Torimiro, Associate Professor of Molecular Biology and Coordinator of Laboratories in the Chantal Biya International Reference Centre for Research on the Prevention and Management of HIV/AIDS, Cameroon, and Chair of the Department of Biochemistry in the Faculty of Medicine and Biomedical Sciences, University of Yaoundé, and to Mr Eusebio Quispe Rodríguez, mayor of the district of Iguaín in Peru. Each laureate, as an individual, will receive US$ 30 000 for their outstanding work in health development.

(Seventeenth meeting, 1 February 2019)

EB144(12) Amendments to the Statutes of the Sasakawa Health Prize[3]

The Executive Board, having considered the report of the Sasakawa Health Prize Selection Panel,[4] decided to revise Articles 4 and 9 of the Statutes of the Sasakawa Health Prize.

(Seventeenth meeting, 1 February 2019)

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[1] Document EB144/40, section 1.

[2] Document EB144/40, section 2.

[3] See Annex 5.

[4] Document EB144/40, section 2(b).

EB144(13) Award of the United Arab Emirates Health Foundation Prize

The Executive Board, having considered the report of the United Arab Emirates Health Foundation Selection Panel,[1] awarded the United Arab Emirates Health Foundation Prize for 2019 jointly to the National Center for Global Health and Medicine of Japan for its contribution to the improvement of public health, both in Japan and, through its Bureau of International Health Cooperation, in developing countries and to Dr Askwar Hilonga of the United Republic of Tanzania for his work in using nanomaterials to improve access to safe drinking water and reduce the number of lives lost to waterborne diseases. The laureates will each receive US$ 20 000.

(Seventeenth meeting, 1 February 2019)

EB144(14) The State of Kuwait Health Promotion Foundation's His Highness Sheikh Sabah Al-Ahmad Al-Jaber Al-Sabah Prize for Research in Health Care for the Elderly and in Health Promotion

The Executive Board, having considered the report of the State of Kuwait Health Promotion Foundation Selection Panel,[2] awarded The State of Kuwait Health Promotion Foundation's His Highness Sheikh Sabah Al-Ahmad Al-Jaber Al-Sabah Prize for Research in Health Care for the Elderly and in Health Promotion for 2019 to the Aging and Fragility in the Elderly Group of the Research Institute of La Paz Hospital of Spain for its outstanding contribution to research in the areas of health care for the elderly and in health promotion. The laureate will receive US$ 20 000.

(Seventeenth meeting, 1 February 2019)

EB144(15) Dr LEE Jong-wook Memorial Prize for Public Health

The Executive Board, having considered the report of the Dr LEE Jong-wook Memorial Prize Selection Panel,[3] awarded the Dr LEE Jong-wook Memorial Prize for Public Health for 2019 jointly to Professor Balram Bhargava from India for his impressive career as a cardiologist and biomedical innovator and to the Health Promotion Unit of the Department of Public Health of Myanmar for its contribution to public health, in particular through its Community Health Clinic model, from concept to implementation. Each laureate will receive US$ 50 000.

(Seventeenth meeting, 1 February 2019)

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[1] Document EB144/40, section 3.

[2] Document EB144/40, section 4.

[3] Document EB144/40, section 5.

ANNEXES

ANNEX 1

Confirmation of amendments to the Staff Rules[1]

[EB144/49 Rev.1 – 16 January 2019]

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

2. The amendments described in section I of this document stem from decisions taken by the United Nations General Assembly at its seventy-third session,[3] on the basis of recommendations made by the International Civil Service Commission (hereinafter the "Commission") in its annual report for 2018.[4]

3. The financial implications of the amendments for the biennium 2018–2019 involve additional costs under the Programme budget 2018–2019. They are set out in the report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board, along with the financial implications beyond the biennium 2018–2019,[5] and in the paragraphs below.

4. The amended Staff Rules are set out in the [appendices] to the present document.

I. AMENDMENTS CONSIDERED NECESSARY IN THE LIGHT OF DECISIONS TAKEN BY THE UNITED NATIONS GENERAL ASSEMBLY AT ITS SEVENTY-THIRD SESSION ON THE BASIS OF RECOMMENDATIONS BY THE COMMISSION

Remuneration of staff in the professional and higher categories

5. The Commission recommended to the General Assembly, and the General Assembly approved, that the new unified base/floor salary scale for the professional and higher categories should be increased by 1.83% through the standard consolidation method of increasing base salary and commensurately reducing post adjustment multiplier points, resulting in no change in net take-home pay, with effect from 1 January 2019.

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[1] See resolutions EB144.R7 and EB144.R8.

[2] The Staff Regulations and Staff Rules are available at https://www.who.int/employment/staff_regulations_rules/staff-rules-en.pdf (accessed 4 April 2019).

[3] United Nations General Assembly, resolutions of the 73rd session (https://www.un.org/en/ga/73/resolutions.shtml, accessed 4 April 2019).

[4] ICSC 2018 annual report (A/73/30) (https://icsc.un.org/library/default.asp?list=AnnualRep, accessed 4 April 2019).

[5] Document EB144/49 Rev.1 Add.1 (see Annex 7 to this document, section on resolutions EB144.R7 and EB144.R8).

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

Remuneration of staff in ungraded positions and the Director-General

7. Consistent with the decision of the General Assembly in respect of the recommendations above, the Director-General proposes, in accordance with Staff Regulation 3.1, that the Executive Board recommend to the Seventy-second World Health Assembly modifications in the salaries of Assistant Directors-General and Regional Directors. Thus, as from 1 January 2019, the gross salary for Assistant Directors-General and Regional Directors would be US$ 179 948 per annum, with a corresponding net salary of US$ 134 266.

8. Based on the adjustments to salaries described above, the salary modification to be authorized by the Health Assembly for the Deputy Directors-General would entail, as from 1 January 2019, a gross salary of US$ 198 315 per annum, with a corresponding net salary of US$ 146 388.

9. The salary adjustments above would also affect the salary of the Director-General. The gross salary to be authorized by the World Health Assembly, as from 1 January 2019, would be US$ 244 571 per annum, with a corresponding net salary of US$ 176 917.

Common scale of staff assessment

10. The Commission recommended to the General Assembly, and the General Assembly approved, the introduction of a common scale of staff assessment, which requires an amendment to Staff Rule 330.1.2 as set out in [Appendix 2] to the present document.

ACTION BY THE EXECUTIVE BOARD

11. [This paragraph contained two draft resolutions, which were adopted as resolutions EB144.R7 and EB144.R8.]

APPENDIX 1 TO THE STAFF RULES

A. SALARY SCALE FOR THE PROFESSIONAL AND HIGHER CATEGORIES SHOWING ANNUAL GROSS SALARIES AND NET EQUIVALENTS AFTER APPLICATION OF STAFF ASSESSMENT (IN UNITED STATES DOLLARS) (effective 1 January 2019)[a]

Level		*I*	*II*	*III*	*IV*	*V*	*VI*	*VII*	*VIII*	*IX*	*X*	*XI*	*XII*	*XIII*
D-2	**Gross**	**143 813**	**146 943**	**150 079**	**153 402**	**156 726**	**160 048**	**163 368**	**166 691**	**170 012**	**173 332**	–	–	–
	Net	110 169	112 360	114 552	116 745	118 939	121 132	123 323	125 516	127 708	129 899	–	–	–
D-1	**Gross**	**128 707**	**131 457**	**134 210**	**136 963**	**139 706**	**142 459**	**145 209**	**147 956**	**150 753**	**153 667**	**156 583**	**159 497**	**162 415**
	Net	99 595	101 520	103 447	105 374	107 294	109 221	111 146	113 069	114 997	116 920	118 845	120 768	122 694
P-5	**Gross**	**110 869**	**113 209**	**115 550**	**117 887**	**120 229**	**122 566**	**124 909**	**127 246**	**129 586**	**131 924**	**134 266**	**136 601**	**138 944**
	Net	87 108	88 746	90 385	92 021	93 660	95 296	96 936	98 572	100 210	101 847	103 486	105 121	106 761
P-4	**Gross**	**90 970**	**93 050**	**95 129**	**97 209**	**99 288**	**101 483**	**103 744**	**106 001**	**108 259**	**110 514**	**112 776**	**115 029**	**117 287**
	Net	72 637	74 218	75 798	77 379	78 959	80 538	82 121	83 701	85 281	86 860	88 443	90 020	91 601
P-3	**Gross**	**74 649**	**76 574**	**78 499**	**80 421**	**82 347**	**84 271**	**86 195**	**88 122**	**90 046**	**91 970**	**93 897**	**95 821**	**97 747**
	Net	60 233	61 696	63 159	64 620	66 084	67 546	69 008	70 473	71 935	73 397	74 862	76 324	77 788
P-2	**Gross**	**57 661**	**59 383**	**61 103**	**62 824**	**64 546**	**66 270**	**67 993**	**69 711**	**71 434**	**73 154**	**74 875**	**76 599**	**78 318**
	Net	47 322	48 631	49 938	51 246	52 555	53 865	55 175	56 480	57 790	59 097	60 405	61 715	63 022
P-1	**Gross**	**44 593**	**45 931**	**47 269**	**48 607**	**49 943**	**51 401**	**52 862**	**54 324**	**55 784**	**57 246**	**58 707**	**60 166**	**61 628**
	Net	37 012	38 123	39 233	40 344	41 453	42 565	43 675	44 786	45 896	47 007	48 117	49 226	50 337

[a] The normal qualifying period for in-grade movement between consecutive steps is one year. The shaded steps in each grade require two years of qualifying service at the preceding step.

B. PAY PROTECTION POINTS FOR STAFF WHOSE SALARIES ARE HIGHER THAN THE MAXIMUM SALARIES ON THE UNIFIED SALARY SCALE (IN UNITED STATES DOLLARS) (effective 1 January 2019)

Level		*Pay protection point 1*	*Pay protection point 2*
P-4	**Gross**	**119 547**	**121 806**
	Net	93 183	94 764
P-3	**Gross**	**99 670**	**101 730**
	Net	79 249	**80** 711
P-2	**Gross**	**80 041**	–
	Net	64 331	–
P-1	**Gross**	**63 088**	–
	Net	51 447	–

Appendix 2

TEXT OF AMENDED STAFF RULES

<table>
<tr><th>Former text</th><th>New text</th></tr>
<tr><td>330. SALARIES
...
330.1.2 For the general service category:
<table><tr><th>Amounts per year US$</th><th>Assessment per cent</th></tr><tr><td>Up to US$ 20 000</td><td>19</td></tr><tr><td>Next US$ 20 000</td><td>23</td></tr><tr><td>Next US$ 20 000</td><td>26</td></tr><tr><td>Remaining assessable payments</td><td>31</td></tr></table></td><td>330. SALARIES
...
330.1.2 For the general service category:
<table><tr><th>Amounts per year US$</th><th>Assessment per cent</th></tr><tr><td><s>Up to US$</s> First 20 000</td><td>19</td></tr><tr><td>Next <s>US$</s> 20 000</td><td>23</td></tr><tr><td>Next <s>US$</s> 20 000</td><td>26</td></tr><tr><td>Next 20 000</td><td>28</td></tr><tr><td>Remaining assessable <s>payments</s> amount</td><td><s>31</s>29</td></tr></table></td></tr>
</table>

ANNEX 2

Text of amended Rules of Procedure of the Executive Board[1]

[EB144/34 – 24 December 2018]

Rule 4

Subject to the terms of any relevant agreement, representatives of the United Nations and of other intergovernmental organizations with which the Organization has established effective relations under Article 70 of the Constitution may participate without vote in the deliberations of meetings of the Board and its committees. Such representatives may also attend and participate without vote in the deliberations of the meetings of subcommittees or other subdivisions if so invited.

Representatives of nongovernmental organizations, international business associations and philanthropic foundations in official relations with the Organization may participate in the deliberations of the Board as is provided in the Framework of Engagement with Non-State Actors.

[NB: in the process of reissuing the *Basic documents*, the Secretariat may add a reference to the page of the *Basic documents* which reproduces the text of the Framework of Engagement with Non-State Actors.]

Rule 28 bis

Proposals for resolutions or decisions to be considered by the Board relating to items of the agenda should be introduced at least fifteen days before the opening of the session and may, in any event, be introduced not later than the close of the first day of the session. However, if a session is scheduled for two days or less, such proposals may be introduced no later than 48 hours prior to the opening of the session. The Board may, if it deems it appropriate, permit the late introduction of such proposals.

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[1] See decision EB144(3).

ANNEX 3

Rules of Procedure of the Executive Board necessary amendments for gender-neutral language[1]

[EB144/33 – 21 December 2018]

1. The Executive Board in decision EB143(7) (2018) requested the Director-General to present the necessary amendments to replace or supplement gender-specific language in the Rules of Procedure of the governing bodies to indicate both feminine and masculine for the Board's consideration and appropriate action at its 144th session.

2. As shown in the examples in the Annex [to the original document], the linguistic requirements of the different languages will need different solutions. As far as the English version of the Rules of Procedure of the governing bodies is concerned, the Secretariat has identified the cases where amendments are necessary in order to replace or supplement gender-specific language. For all other languages, which are characterized by substantial grammatical inflexion and where full implementation of the principle would affect the readability of the final text, it is proposed to follow current United Nations practice. In such cases, the masculine grammatical form will continue to be applied as including both masculine and feminine, in line with resolution WHA57.8 (2004) and prevailing linguistic norms. It should be noted that this approach is already followed in the WHO European Region where the English version of the Rules of Procedure of the Regional Committee uses language referring to both feminine and masculine, while the other language versions of the Rules use the masculine grammatical form to include both feminine and masculine.

3. In light of the above three options are available:

(a) to maintain the current practice, which is that the use of one gender was considered as including a reference to the other unless the context otherwise required in accordance with resolution WHA57.8 (2004);

(b) to proceed with the required amendments to replace or supplement gender-specific language in the English version of the Rules of Procedure of the governing bodies only, while continuing to follow the United Nations' practice described in paragraph 2 in the other five official and working languages;

(c) to proceed with the required amendments to replace or supplement gender specific language in the Rules of Procedure of the governing bodies in all official and working languages of WHO's governing bodies.

[1] See decision EB144(4).

ACTION BY THE EXECUTIVE BOARD

4. The Board is invited to note the report and provide further guidance in relation to the three options provided in paragraph 3 above.

5. [This paragraph contained the text of three options for a draft decision, the second of which was adopted as decision EB144(4).]

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ANNEX 4

Non-State actors admitted into, or maintained in, official relations with WHO by virtue of decision EB144(5)[1]

[EB144/37 – 13 December 2018]

1. Action Contre la Faim International*
2. Aga Khan Foundation*
3. AMREF Health Africa*
4. ASSITEB-BIORIF*
5. CBM Christoffel Blindenmission Christian Blind Mission e.V.*
6. Consumers International*
7. Council for International Organizations of Medical Sciences*
8. Council on Health Research for Development*
9. European Association for Injury Prevention and Safety Promotion*
10. Framework Convention Alliance on Tobacco Control*
11. International Agency for the Prevention of Blindness*
12. International Air Transport Association*
13. International Alliance for Biological Standardization*
14. International Alliance of Patients' Organizations*
15. International Association for the Study of Pain*
16. International Association of Cancer Registries*
17. International College of Surgeons*
18. International Council for Standardization in Haematology*
19. International Council of Nurses*
20. International Federation for Medical and Biological Engineering*
21. International Federation of Biomedical Laboratory Science*
22. International Federation of Clinical Chemistry and Laboratory Medicine*
23. International Federation of Fertility Societies*
24. International Federation of Health Information Management Associations*
25. International Federation of Hospital Engineering*
26. International Federation of Medical Students' Associations*
27. International Federation of Pharmaceutical Manufacturers and Associations*
28. International Federation of Surgical Colleges*
29. International Food Policy Research Institute*
30. International Hospital Federation*
31. International Life Saving Federation*
32. International Medical Informatics Association*
33. International Network for Cancer Treatment and Research*
34. International Pharmaceutical Federation*
35. International Pharmaceutical Students' Federation*

[1] Based on reports of collaboration for the period under review, 2016–2018, the Secretariat invited the Board to consider renewal in official relations of those non-State actors whose names are followed by an asterisk. The other non-State actors are the subject of decision EB144(5).

36. International Society for Telemedicine & eHealth*
37. International Society of Blood Transfusion*
38. International Society of Orthopaedic Surgery and Traumatology*
39. International Society of Radiology*
40. International Society of Physical and Rehabilitation Medicine*
41. International Society on Thrombosis and Haemostasis*
42. International Union of Architects*
43. International Union of Basic and Clinical Pharmacology*
44. International Water Association*
45. Medicus Mundi International – Network Health for All*
46. Nutrition International*
47. OXFAM*
48. Pasteur International Network Association*
49. Project ORBIS International, Inc. (ORBIS International)*
50. The Albert B. Sabin Vaccine Institute, Inc.
51. The Cochrane Collaboration*
52. The International League of Dermatological Societies
53. The International Society for Burn Injuries*
54. The International Society for Quality in Health Care Incorporated*
55. The International Society of Radiographers and Radiological Technologists*
56. The Network: Towards Unity For Health*
57. The Royal National Lifeboat Institution
58. The Task Force for Global Health
59. The Transplantation Society*
60. The World Medical Association, Inc.*
61. United Nations Foundation, Inc.
62. Women Deliver, Inc.
63. World Association of Societies of Pathology and Laboratory Medicine*
64. World Blind Union*
65. World Cancer Research Fund International*
66. World Council of Churches*
67. World Council of Optometry*
68. World Federation for Medical Education*
69. World Federation for Ultrasound in Medicine and Biology*
70. World Federation of Acupuncture-Moxibustion Societies*
71. World Federation of Chiropractic*
72. World Federation of Nuclear Medicine and Biology
73. World Federation of Public Health Associations*
74. World Federation of Societies of Anaesthesiologists*
75. World Organization of Family Doctors*
76. World Self-Medication Industry*
77. World Vision International*
78. Worldwide Network for Blood and Marrow Transplantation*

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ANNEX 5

Amended Statutes of the Sasakawa Health Prize[1]

[EB144/40, section 2(b) – 1 February 2019]

Article 4
Prize

The Sasakawa Health Prize shall consist of a statuette and a sum of money of the order of US$ 30 000 to be given to a person or persons, and/or of the order of US$ 40 000 to be given to an institution or institutions, or a nongovernmental organization or organizations having accomplished outstanding innovative work in health development, such as the promotion of given health programmes or notable advances in primary health care, in order to encourage the further development of such work. Current and former staff members of the World Health Organization, and current members of the Executive Board, shall be ineligible to receive the Prize. The sum of money, derived from the income and/or the undistributed reserves, shall be determined by the Prize Selection Panel. The Prize shall be presented during a meeting of the World Health Assembly to the recipient(s) or to a person(s) representing the recipient(s).

…

Article 9
Revision of the Statutes

On the motion of one of its members, the Prize Selection Panel may propose revision of the present Statutes. Any such motion, if endorsed by a majority of the members of the Selection Panel, shall be submitted to the Executive Board for its approval.

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[1] As adopted in decision EB144(12).

ANNEX 6

Establishment of the Nelson Mandela Award for Health Promotion[1]

[EB144/40 Add.1 – 1 February 2019]

PROPOSAL

1. At the Seventy-first World Health Assembly in 2018,[2] the health ministers of the Member States of the African Region in their Nelson Mandela Centenary Declaration proposed the establishment of an award for best institutional or individual health promoter. The award is proposed to be administered by the Director-General and entitled the Nelson Mandela Award for Health Promotion.

2. The award is proposed to be given annually to one or more individuals or organizations for a significant individual or institutional contribution to health promotion.

3. The statutes are attached at [Appendix 1 and streamlined measures for bestowing the first Nelson Mandela Award for Health Promotion are attached at Appendix 2].

BACKGROUND

4. The Director-General is the administrator of 12 foundation prizes and fellowships.[3]

5. These foundations have been generally established by, or in memory of, eminent health personalities. The Léon Bernard Foundation Prize is a legacy of the League of Nations, whereas the others have been created since the establishment of WHO.

6. With the exception of the Francesco Pocchiari Fellowship, the procedure for the award of prizes is similar. Any national health authority or a previous laureate can nominate a candidate for a prize. For each award, there is a committee and/or selection panel, usually consisting of three members, including the Chairman of the Executive Board.

7. The usual procedure is for the committees or panels to recommend one or more candidates to the Board, which makes the final selection; the prizes are formally awarded to the laureates during the Health Assembly or during sessions of regional committees.

ACTION BY THE EXECUTIVE BOARD

8. [This paragraph contained the text of a draft decision, which was adopted as decision EB144(9).]

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[1] See decision EB144(9).

[2] Sixth plenary meeting, 25 May 2018.

[3] Awards (see https://www.who.int/governance/awards/en/, accessed 29 January 2019).

Appendix 1

STATUTES OF THE NELSON MANDELA AWARD FOR HEALTH PROMOTION

Article 1 – Establishment

Under the title of the "Nelson Mandela Award for Health Promotion", an award is established within the framework of the World Health Organization, which shall be governed by the following provisions.

Article 2 – The Founder

The award is established upon the initiative of the Ministers of Health of Member States of the African Region.

Article 3 – Award

1. The Nelson Mandela Award for Health Promotion shall be given to a person or persons, an institution or institutions, a governmental or nongovernmental organization or organizations, who or which has/have made a significant contribution to health promotion.

2. The award aims to reward work that has extended far beyond the call of normal duties, and it is not intended as a reward for excellent performance of duties normally expected of an official occupying a government position or of a governmental or nongovernmental institution.

3. In recognition of the humility of Nelson Mandela, the award given to each laureate shall be a plaque. The award shall be given annually.

4. The award shall be presented during the Health Assembly to the laureate(s) or, in their absence, to a person(s) representing them.

Article 4 – Proposal and selection of candidates

1. Any national health administration of a Member State of the World Health Organization, or any former recipient of the award, may put forward the name of a candidate for the award. The nomination must be accompanied by a written statement of the reasons for proposing the candidate. The same candidature may be submitted several times if unsuccessful.

2. Proposals shall be submitted to the Administrator, who shall submit them to the Award Selection Panel.

3. Current and former staff members of the World Health Organization and current members of the Executive Board shall be ineligible to receive the award.

Article 5 – Award Selection Panel

1. The Nelson Mandela Award for Health Promotion Selection Panel ("the Award Selection Panel") shall consist of the Chairman and the first Vice-Chairman of the Executive Board, and a member elected by the Executive Board from among its members from the African Region, for a period not exceeding his or her term of office on the Executive Board.

2. The presence of three members of the Award Selection Panel shall be required for the taking of decisions. The Panel shall take decisions by a majority of its members.

Article 6 – Proposal of the Award Selection Panel

The Award Selection Panel, in a private meeting, shall consider the candidates for the award, and shall propose the name(s) of the recipient(s) of the award to the Executive Board. The proposal shall be considered by the Executive Board, which shall decide who or which organization(s) the recipient(s) of the award shall be.

Article 7 – The Administrator

1. The Director-General of the World Health Organization shall be the Administrator of the award, and shall act as the Secretary of the Award Selection Panel.

2. The Administrator shall be responsible for:

(a) the execution of the decisions taken by the Award Selection Panel within the limits of its powers, as defined in these Statutes;

(b) the observance of the present Statutes and, generally, the administration of the award in accordance with the present Statutes.

Article 8 – Revision of the Statutes

On the proposal of one of its members, the Award Selection Panel may propose the revision of the present Statutes. Any such proposal, if endorsed by a majority of its members, shall be submitted to the Executive Board for approval.

Appendix 2

STREAMLINED MEASURES FOR BESTOWING THE FIRST NELSON MANDELA AWARD FOR HEALTH PROMOTION IN 2019

Composition of the Award Selection Panel

The Award Selection Panel will exceptionally be composed of the Officers of the Executive Board, excluding the Chairman of the Board.

Decision-making

The Chairman of the Board will consider the recommendation of the Panel and decide who or which organization(s) the recipient(s) of the award will be, on behalf of the Board.

Timeline

- Immediately after the [adoption by the Board at its 144th session of a decision] to establish the award and its statutes, a circular letter will be sent to Member States inviting nominations for the award.

- Mid-April 2019: the Secretariat will collect and distribute the relevant documentation to the Panel members and convene a virtual meeting of the Panel, for it to recommend a recipient(s).

- End of April 2019: the Chairman of the Board will consider the proposal and decide on the recipient(s) of the award, on behalf of the Board.

- Beginning of May 2019: the first laureate(s) of the award will be announced, and the information will be included in the relevant official documentation of the Seventy-second World Health Assembly.

- End of May 2019: the award ceremony will take place in Geneva at the Palais des Nations, during the Health Assembly.

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ANNEX 7

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

Resolution EB144.R4	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:** 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 EB144.R5 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

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:** Six years in total. Implementation in one country takes about two years; implementation can be carried out in parallel in several countries.
B.	**Resource implications for the Secretariat for implementation of the resolution**
1.	**Total resource requirements to implement the resolution, in US$ millions:** US$ 9.83 million over six years (up to mid-2025).
2.a.	**Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US$ millions:** US$ 2.71 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$ 3.56 million.
4.	**Estimated resource requirements in future programme budgets, in US$ millions:** US$ 3.56 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$ 2.71 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 EB144.R7 Confirmation of amendments to the Staff Rules: salaries of staff in the professional and higher categories

Resolution EB144.R8 Confirmation of amendments to the Staff Rules: salaries of staff in ungraded positions and 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.

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:

With respect to **resolution EB144.R7**, the relevant amendments to the Staff Rules took effect from 1 January 2019.

With respect to **resolution EB144.R8**, the relevant adjustments in remuneration took effect from 1 January 2019.

There is no defined end date for implementation.

B.	Resource implications for the Secretariat for implementation of the resolution
1.	**Total resource requirements to implement the resolution, in US$ millions:** The resource requirements for both resolutions are already included within what is planned under the approved Programme budget 2018–2019. For both resolutions, 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.
2.a.	**Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US$ millions:** Not applicable.
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:** 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:** 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.

Resolution EB144.R9	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 EB144.R10	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:** 4.2.1 Equitable integrated, people-centred service delivery systems in place in countries and public health approaches strengthened 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 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
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:** Twelve 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 EB144.R11 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.

3. Any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the approved Programme budget 2018–2019:

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.

4. Estimated implementation time frame (in years or months) to achieve the resolution:

Three years: 2019–2021.

B. Resource implications for the Secretariat for implementation of the resolution

1. Total resource requirements to implement the resolution, in US$ millions:

US$ 124.4 million.

2.a. Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US$ millions:

US$ 41.7 million.

2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2018–2019, in US$ millions:

An additional US$ 10 million for 2019.

3. Estimated resource requirements in the Programme budget 2020–2021, in US$ millions:

US$72.7 million.

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.

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$ 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 EB144.R12 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

Decision EB144(1) 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

1. Output(s) in the approved Programme budget 2018–2019 to which this decision will contribute:

2.1.1. Development and implementation of national multisectoral policies and plans to prevent and control noncommunicable diseases accelerated

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

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

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:** Seven years. All activities referred to in the 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.
B.	**Resource implications for the Secretariat for implementation of the decision**
1.	**Total resource requirements to implement the decision, in US$ millions:** US$ 602 million (2019–2025).
2.a.	**Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US$ millions:** US$ 86 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$ 172 million.
4.	**Estimated resource requirements in future programme budgets, in US$ millions:** US$ 344 million.
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$ 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 EB144(2) Accelerating the elimination of cervical cancer as a global public health problem

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:

1.5.1. Implementation and monitoring of the global vaccine action plan with emphasis on strengthening service delivery and immunization monitoring in order to achieve the goals for the Decade of Vaccines

2.1.1. Development and implementation of national multisectoral policies and plans to prevent and control noncommunicable diseases accelerated

2.1.5. Enhanced coordination of activities, multistakeholder engagement and action across sectors in collaborative work with relevant United Nations system organizations, other intergovernmental organizations and non-State actors, to support governments to meet their commitments on the prevention and control of noncommunicable diseases

3.1.2. Countries enabled to implement and monitor effective interventions to cover unmet needs in sexual and reproductive health

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$ 1.97 million.

2.a. Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US$ millions:

US$ 1.97 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:**

Zero.

– **Remaining financing gap in the current biennium:**

US$ 1.97 million.

– **Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:**

US$ 1 million.

Table. Breakdown of estimated resource requirements (in US$ thousands)

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2018–2019 resources already planned	Staff	–	–	–	–	–	–	605	605
	Activities	100	100	100	100	100	100	760	1360
	Total	100	100	100	100	100	100	1365	1965

Decision EB144(3)	WHO reform processes, including the transformation agenda, and implementation of United Nations development system 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.

Decision EB144(4)	WHO reform processes, including the transformation agenda, and implementation of United Nations development system 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 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.
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:** 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 *Basic documents*).
B.	**Resource implications for the Secretariat for implementation of the decision**
1.	**Total resource requirements to implement the decision, in US$ millions:** US$ 0.06 million, for the production of the next edition of *Basic documents*. The costs of updating the Rules of Procedure of the governing bodies in *Basic documents* 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.
2.a.	**Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US$ millions:** US$ 0.03 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$ 0.03 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$ 0.03 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.

Decision EB144(5) Engagement with non-State actors

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:

6.1.2 Effective engagement with other United Nations agencies and non-State actors in building a common health agenda that responds to Member States' priorities

6.2.1 Accountability ensured and corporate risk management strengthened at all levels of the Organization

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:

Official relations with non-State actors is a standing agenda item of the January session of the Executive Board. Each year one third of non-State actors are reviewed and, where applicable, renewed for a three-year period based on an agreed workplan.

B. Resource implications for the Secretariat for implementation of the decision

1. Total resource requirements to implement the decision, in US$ millions:

Resources (both income and expenses) associated with interactions with non-State actors in official relations are part of the regular planning cycle and are not calculated separately.

2.a. Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US$ millions:

Not applicable.

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:

Not applicable.

4.	**Estimated resource requirements in future programme budgets, in US$ millions:** To be reassessed based on evaluation of the Framework of Engagement with Non-State Actors (FENSA).
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:** 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.

Decision EB144(6)	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.