World Health Organization

EXECUTIVE BOARD
146th session

Extracts from document WHA72/2019/REC/1 for consideration by the Executive Board at its 146th session[1]

[1] The present document is made available in order to assist the Executive Board in its deliberations. The final version of document WHA72/2019/REC/1 will be made available in due course on the Governance website at http://apps.who.int/gb/or/.

RESOLUTIONS

WHA72.1 Programme budget 2020–2021

The Seventy-second World Health Assembly,

Having considered the Proposed programme budget 2020–2021;[1]

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

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

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

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

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

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

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

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

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

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

[1] Document A72/4.

[2] Document A72/63.

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

1. APPROVES the programme of work, as outlined in the Proposed programme budget 2020–2021, and its strategic priorities and other areas, noting also the background information on its operationalization;

2. APPROVES the budget for the financial period 2020–2021, under all sources of funds, namely, assessed and voluntary contributions, of US$ 5840.4 million;

3. ALLOCATES the budget for the financial period 2020–2021 to the following strategic priorities and other areas:

Strategic priorities

1. One billion more people benefiting from universal health coverage, US$ 1358.8 million;

2. One billion more people better protected from health emergencies, US$ 888.8 million;

3. One billion more people enjoying better health and well-being, US$ 431.1 million;

4. More effective and efficient WHO providing better support to countries, US$ 1090.0 million (including financing the United Nations Resident Coordinator system in accordance with relevant resolutions of the United Nations General Assembly;

Other areas

- Polio eradication (US$ 863.0 million), special programmes (US$ 208.7 million) totalling US$ 1071.7 million;

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

4. RESOLVES that the budget will be financed as follows:

- by net assessments on Member States adjusted for estimated Member State non-assessed income, for a total of US$ 956.9 million;

- from voluntary contributions, for a total of US$ 4883.5 million;

5. FURTHER RESOLVES that the gross amount of the assessed contribution for each Member State shall be reduced by the sum standing to their credit in the Tax Equalization Fund; that this reduction shall be adjusted in the case of those Members that require staff members to pay income taxes on their WHO emoluments, taxes which the Organization reimburses to the said staff members; and that the amount of such tax reimbursements is estimated at US$ 21.0 million, resulting in a total assessment on Members of US$ 977.9 million;

6. DECIDES that the Working Capital Fund shall be maintained at its existing level of US$ 31.0 million;

7. AUTHORIZES the Director-General to use the assessed contributions together with the voluntary contributions, subject to the availability of resources, to finance the budget as allocated in paragraph 3, up to the amounts approved;

8. FURTHER AUTHORIZES the Director-General, where necessary, to make budget transfers among the four strategic priorities, up to an amount not exceeding 5% of the amount allocated to the strategic priority from which the transfer is made. Any such transfers will be reported with an explanation in the statutory reports to the respective governing bodies;

9. FURTHER AUTHORIZES the Director-General, where necessary, to incur additional expenditures in the emergency operations and appeals area, subject to availability of resources;

10. FURTHER AUTHORIZES the Director-General, where necessary, to incur additional expenditures in the special programmes component of the budget beyond the amount allocated for this component, as a result of additional governance and resource mobilization mechanisms, as well as their budget cycle, which inform the annual and/or biennial budgets for these special programmes, subject to availability of resources;

11. REQUESTS the Director-General:

(1) to continue developing the results framework in consultation with Member States, including through the regional committees, and to present it to the Executive Board at its 146th session;

(2) to present a resource mobilization strategy to the Executive Board at its 146th session;

(3) to submit regular reports to Member States on the state of financing and implementation of the Programme budget, including a mid-term results report to the Health Assembly, through the Executive Board and its Programme, Budget and Administration Committee;

(4) to submit to the Seventy-fifth World Health Assembly in 2022, a report on: the implementation of the entire Programme budget over the period 2020–2021; and outputs by major offices and at the country level, including as measured by balanced scorecards, and, as appropriate, by outcome indicators;

(5) to control costs and secure efficiencies across the entire Organization, and to report to the Health Assembly with detailed information on savings and efficiencies, through the Executive Board and its Programme, Budget and Administration Committee.

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

WHA72.2 Primary health care[1]

The Seventy-second World Health Assembly,

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

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

[2] Document A72/12.

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

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

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

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

1. WELCOMES the Declaration of Astana adopted at the Global Conference on Primary Health Care in Astana on 25 October 2018;

2. URGES Member States[1] to take measures to share and implement the vision and commitments of the Declaration of Astana according to national contexts;

3. CALLS UPON all relevant stakeholders:

(1) to align their actions and support to national policies, strategies and plans, in the spirit of partnership and effective development cooperation, in implementing the vision and commitments of the Declaration of Astana;

(2) to provide support to Member States in mobilizing human, technological, financial and information resources to help to build strong and sustainable primary health care, as envisaged in the Declaration of Astana;

4. REQUESTS the Director-General:

(1) to support Member States, as appropriate, in strengthening primary health care, including the implementation of the vision and commitments of the Declaration of Astana in coordination with all relevant stakeholders;

(2) to develop, in consultation with, and with the involvement of more expertise from, Member States, and in time for consideration by the Seventy-third World Health Assembly, an operational framework for primary health care, to be taken fully into account in the WHO general programmes of work and programme budgets in order to strengthen health systems and support countries in scaling-up national implementation efforts on primary health care;

(3) to ensure that WHO promotes the vision and commitments in the Declaration of Astana in its work and overall organizational efforts, and enhances institutional capacity and leadership

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

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.

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

WHA72.3 Community health workers delivering primary health care: opportunities and challenges[1]

The Seventy-second World Health Assembly,

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

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

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

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

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

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

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

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

[2] Document A72/13.

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

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 the Global Strategy on Human Resources for Health: Workforce 2030, with the Global Strategy identifying the opportunity, inter alia, to optimize the performance, quality and impact of community health workers for the achievement of universal health coverage and the Sustainable Development Goals;

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

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

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

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

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

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

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

Highlighting the role of community health workers in advancing equitable access to safe, comprehensive health services in urban and rural areas and the reduction of inequities, including with respect to residence, gender, education and socioeconomic position, as well as their role in gaining the trust and engagement of the communities served;

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

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

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

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

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

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

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

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

(4) to allocate, as part of broader health workforce strategies and financing, adequate resources from domestic budgets and from a variety of sources, as appropriate, to the capital and recurrent

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

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

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 on community health worker programmes, through the use of national health workforce accounts, as appropriate, thus enabling national reporting on Sustainable Development Goal indicator 3.c.1 on the density and distribution of their health workforce;

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

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

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

5. REQUESTS the Director-General:

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

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

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

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

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

(6) to strengthen WHO's capacity and leadership on human resources for health at all levels of the Organization through engagement with all relevant stakeholders and provision of high-quality and timely technical assistance from global, regional and country levels to accelerate implementation of: resolution WHA69.19 (2016) on the global strategy on human resources for health; resolution WHA70.6 (2017) on human resources for health and implementation of the outcomes of the United Nations' High-Level Commission on Health Employment and Economic Growth, in which the Health Assembly adopted "Working for Health": the ILO, OECD, WHO five-year action plan for health employment and inclusive economic growth (2017–2021); and future work on community health worker programmes;

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

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

WHA72.4 Preparation for the high-level meeting of the United Nations General Assembly on universal health coverage[1]

The Seventy-second World Health Assembly,

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

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

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

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

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

Recognizing that through the adoption of the 2030 Agenda and its Sustainable Development Goals on 25 September 2015, Heads of State and Government and High Representatives made a bold

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

[2] Document A72/14.

commitment to achieve universal health coverage by 2030, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all;

Recognizing also that Heads of State and Government and High Representatives committed themselves to ensuring, by 2030, universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes;

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

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

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

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

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

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

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

Recalling United Nations General Assembly resolution 73/2 of 10 October 2018 on the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, in which Heads of State and Government and representatives of States and Governments committed, inter alia, to promote increased access to affordable, safe, effective and quality medicines and diagnostics and other technologies, reaffirming the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement), as amended, and also reaffirming the Doha Declaration on the TRIPS Agreement and Public Health (2001), which recognizes that intellectual property rights should be interpreted and implemented in a manner supportive of the right of Member States to protect public health and, in particular, to promote access to medicines for all, and which notes the need for appropriate incentives in the development of new health products;

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

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

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

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

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

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

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

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

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

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

Recognizing the fundamental role of primary health care in achieving universal health coverage and targets of the health-related Sustainable Development Goals, as envisioned in the Declaration of Astana endorsed at the Global Conference on Primary Health Care (Astana, Kazakhstan, 25 and

26 October 2018), and in providing equitable access to a comprehensive range of services and care that are people-centred, gender-sensitive, high quality, safe, integrated, accessible, available and affordable, and that contribute to the health and well-being of all;

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

1. URGES Member States:[1]

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

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

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

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

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

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

(7) to invest in an adequate, competent and committed health workforce and promote the recruitment, development, training, and retention of the health workforce in developing countries,

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

especially in least developed countries and small island developing States, by active implementation of the Global Strategy on Human Resources for Health: Workforce 2030;

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

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

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

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

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

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

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

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

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

3. REQUESTS the Director-General:

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

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

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

(4) to produce a report on universal health coverage as a technical input to facilitate informed discussions at the high-level meeting of the United Nations General Assembly on universal health coverage;

(5) to make the best use of International Universal Health Coverage Day to drive the universal health coverage agenda, including by encouraging increased political commitment to universal health coverage;

(6) to submit biennial reports on progress made in implementing this resolution, starting with the Seventy-third World Health Assembly in 2020 and ending with the Eighty-third World Health Assembly in 2030, as part of existing reporting on resolution WHA69.11 (2016).

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

WHA72.5 Antimicrobial resistance[1]

The Seventy-second World Health Assembly,

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

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

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

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

Recalling resolution WHA68.7 (2015) in which the Health Assembly adopted the global action plan on antimicrobial resistance, which lays out five strategic objectives (improve awareness and understanding of antimicrobial resistance; strengthen knowledge through surveillance and research;

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

[2] Document A72/18.

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

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

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

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

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

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

2. URGES Member States:[1]

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

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

(3) to further enhance the prudent use of all antimicrobials, and consider developing and implementing clinical guidelines and criteria according to which critically important

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

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

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

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

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

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

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

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

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

4. REQUESTS the Director-General:

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

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

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

(4) to keep Member States regularly informed of WHO's work with the Tripartite and UNEP, as well as with other United Nations organizations, to ensure a coordinated effort on workstreams; and informed of their progress in developing and implementing multisectoral approaches;

(5) to consult regularly with Member States, and other relevant stakeholders, to adjust the process and scope of the global development and stewardship framework,[1] considering the work of the Interagency Coordination Group on Antimicrobial Resistance in order to ensure a unified and non-duplicative effort;

(6) to support Member States to mobilize adequate predictable and sustained funding and human and financial resources and investment through national, bilateral and multilateral channels to support the development and implementation of national action plans, research and development on existing and new antimicrobial medicines, diagnostics, and vaccines, and other technologies, and strengthening of related infrastructure, including through engagement with multilateral development banks and traditional and voluntary innovative financing and investment mechanisms, based on priorities and local needs set by governments and on ensuring public return on investment;[2]

(7) to collaborate with the World Bank and other financial institutions, OECD, and regional economic communities, in order to continue to make and apply the economic case for sustainable investment in antimicrobial resistance;

(8) to facilitate, in consultation with the United Nations Secretary-General and the Tripartite and UNEP, the development of a process to allow Member States to consider the Secretary-General's report requested in United Nations General Assembly resolution 71/3 (2016);

(9) to maintain and systematically update the WHO list of Critically Important Antimicrobials for human medicine;

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

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

WHA72.6 Global action on patient safety[1]

The Seventy-second World Health Assembly,

Having considered the report by the Director-General on patient safety: global action on patient safety;[2]

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

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

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

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

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

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

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

Recognizing that the safety of patients during the provision of health services that are safe and of high quality is a prerequisite for strengthening health care systems and making progress towards

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

[2] Document A72/26.

effective universal health coverage under Sustainable Development Goal 3 (Ensure healthy lives and promote health and well-being for all at all ages);

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

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

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

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

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

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

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

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

1. ENDORSES the establishment of World Patient Safety Day, to be marked annually on 17 September in order to increase public awareness and engagement, enhance global understanding, and work towards global solidarity and action by Member States to promote patient safety;

2. URGES Member States:[1]

(1) to recognize patient safety as a health priority in health sector policies and programmes, making it an essential component for strengthening health care systems in order to achieve universal health coverage;

(2) to assess and measure the nature and magnitude of the problem of patient safety, including risks, errors, adverse events and patient harm at all levels of health service delivery, including through reporting, learning and feedback systems that incorporate the perspectives of patients and their families, and to take preventive action and implement systematic measures to reduce risks to all individuals;

(3) to develop and implement national policies, legislation, strategies, guidance and tools, and deploy adequate resources, in order to strengthen systems and ensure the safety of all health services, as appropriate;

(4) to work in collaboration with other Member States, civil society organizations, patients' organizations, professional bodies, academic and research institutions, industry and other relevant stakeholders to promote, prioritize and embed patient safety in all health policies and strategies;

(5) to share and disseminate best practices and encourage mutual learning to reduce patient harm through regional and international collaboration;

(6) to integrate and implement patient safety strategies in all clinical programmes and risk areas, as appropriate, to prevent avoidable harm to patients related to health care procedures, products and devices, including in the areas of medication safety, surgical safety, infection control, sepsis management, diagnostic safety, environmental hygiene and infrastructure, injection safety, blood safety and radiation safety, as well as to minimize the risk of inaccurate or late diagnosis and treatment, and to pay special attention to at-risk groups;

(7) to promote a safety culture by providing basic training to all health professionals, developing a blame-free patient safety incident reporting culture through open and transparent systems that identify, and learn from examining, causative and contributing factors of harm, addressing human factors, and building leadership and management capacity and efficient multidisciplinary teams, in order to increase awareness and ownership, improve outcomes for patients and reduce the costs related to adverse events at all levels of health systems;

(8) to build sustainable human resource capacity, through multisectoral and interprofessional competency-based education and training, based on the WHO patient safety curricula and continuous professional development, to promote a multidisciplinary approach, and to build an appropriate working environment that optimizes the delivery of safe health services;

(9) to promote research, including translational research, to support the provision of safer health services and long-term care;

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

(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 to promote all aspects of patient safety including progress towards reaching national milestones, in collaboration with relevant stakeholders;

(14) to consider participating in the annual Global Ministerial Summits on Patient Safety;

3. INVITES international organizations and other relevant stakeholders to collaborate with Member States in promoting and supporting patient safety initiatives, including marking World Patient Safety Day annually;

4. REQUESTS the Director-General:

(1) to emphasize patient safety as a key strategic priority in WHO's work across the universal health coverage agenda;

(2) to develop normative guidance on minimum standards, policies, best practice and tools for patient safety, including on safety culture, human factors, hygienic infrastructure, clinical governance and risk management;

(3) to provide technical support to Member States, especially low- and middle-income countries, where appropriate and where requested, to help to build national capacities in their efforts to assess, measure and improve patient safety, in collaboration with professional associations, as appropriate, and to create a safety culture, as well as ensuring effective prevention of health care-associated harm, including infections, by building capacity in leadership and management, and open and transparent systems that identify and learn from the causes of harm;

(4) to provide support to Member States, on request, in establishing and/or strengthening patient safety surveillance systems;

(5) to strengthen global patient safety networks to share best practice and learning and foster international collaboration including through a global network of patient safety trainers, and to work with Member States, civil society organizations, patients' organizations, professional associations, academic and research institutions, industry and other relevant stakeholders in building safer health care systems;

(6) to provide, on request, technical support and normative guidance on the development of human resource capacity in Member States through interprofessional competency-based

education and training based on WHO patient safety curricula, and, in consultation with Member States, develop "training-of-trainers" programmes for patient safety education and training, and develop global and regional networks of professional educational councils to promote education on patient safety;

(7) to develop and manage, in consultation with Member States, systems for global sharing of learning from patient safety incidents, including through reliable and systematic reporting, data analysis and dissemination systems;

(8) to design, launch and support Global Patient Safety Challenges', and to develop and implement strategies, guidance and tools to support Member States in implementing each Challenge, using the best available evidence;

(9) to promote and support the application of digital technologies and research, including translational research for improving the safety of patients;

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

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

(12) to formulate a global patient safety action plan in consultation with Member States[1] and all relevant stakeholders, including in the private sector, for submission to the Seventy-fourth World Health Assembly in 2021 through the Executive Board at its 148th session;

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

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

WHA72.7 Water, sanitation and hygiene in health care facilities[2]

The Seventy-second World Health Assembly,

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

Recalling the Declaration of Astana endorsed at the Global Conference on Primary Health Care (Astana, Kazakhstan, 25 and 26 October 2018) which envisages strengthening primary health care as the most inclusive, effective and efficient approach to enhance people's physical and mental health, as

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

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

[3] Document A72/27.

well as social well-being, and that primary health care is a cornerstone of a sustainable health system for universal health coverage and health-related Sustainable Development Goals;

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

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

Noting that without sufficient and safe water, sanitation and hygiene services in health care facilities, countries will not achieve the targets set out in Sustainable Development Goal 3 (Ensure healthy lives and promote health and well-being for all at all ages) and Goal 6 (Ensure availability and sustainable management of water and sanitation for all), including reducing maternal and newborn mortality and achieving effective universal health coverage, and those in Sustainable Development Goals 1 (End poverty in all its forms everywhere), 7 (Ensure access to affordable, reliable, sustainable and modern energy for all,), 11 (Make cities and human settlements inclusive, safe, resilient and sustainable) and 13 (Take urgent action to combat climate change and its impacts);

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

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

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

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

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

Noting that the Director-General's report to the Seventy-first World Health Assembly on health, environment and climate 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 to establish accountability mechanisms to reinforce standards and practice;

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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; 2017 (https://www.who.int/water_sanitation_health/publications/water-and-sanitation-for-health-facility-improvement-tool/en/, accessed 4 September 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).

(4) to set targets within health policies and integrate indicators for safe water, sanitation and hygiene and infection prevention and control[1] into national monitoring mechanisms to establish baselines, track progress, and track health system performance on a regular basis;

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

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

(7) to align their strategies and approaches with the global effort for safe water, sanitation and hygiene in health care facilities[2] 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 an adequately sized and well-trained health workforce (including health care workers, cleaners and engineers to manage safe water, sanitation and hygiene services, provide ongoing maintenance and operations and perform appropriate safe water, sanitation and hygiene and infection prevention and control practices) including investing in strong pre-service and ongoing in-service education and training programmes for all levels of staff;

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

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

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

2. INVITES international, regional and local partners:

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

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

3. REQUESTS the Director-General:

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

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

(3) to catalyse the mobilization of domestic and external resources from the public and private sectors, and to support the development of national business cases for investment in safe water, sanitation and hygiene and infection prevention and control in health care facilities;

(4) to continue to raise the profile of safe water, sanitation and hygiene and infection prevention and control in health care facilities within WHO and at high-level political forums, and to work with other United Nations agencies in order to respond to the United Nations Secretary-General's call to action in a coordinated manner;

(5) to work with Member States and partners to review, update and implement the global action plan on antimicrobial resistance and support Member States in the development of national road maps and targets for safe water, sanitation and hygiene in health care facilities;

(6) to work with partners to adapt existing reporting mechanisms and, if necessary, develop new such mechanisms in order to capture and monitor progress on the coordination, implementation, financing, access, quality and governance of safe water, sanitation and hygiene and infection prevention and control in health care facilities, according to the established indicator reporting methodology for Sustainable Development Goal 6 (Ensure availability and sustainable management of water and sanitation for all);[1]

(7) to support implementation and coordination of safe water, sanitation and hygiene and basic infection prevention and control measures in health care facilities and triage centres in times of

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

crisis and humanitarian emergencies through the Health and WASH clusters, leveraging partnerships to prevent disease outbreaks in these contexts;

(8) to report on progress in the implementation of the present resolution to the Health Assembly in 2021 and 2023.

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

WHA72.8 Improving the transparency of markets for medicines, vaccines, and other health products[1,2]

The Seventy-second World Health Assembly,

Having considered the report by the Director-General on access to medicines and vaccines[3] and its annex entitled "draft road map for access to medicines, vaccines, and other health products, 2019–2023" and the report by the Director-General on medicines, vaccines and health products: cancer medicines,[4] pursuant to resolution WHA70.12 (2017) on cancer prevention and control in the context of an integrated approach;

Recognizing the critical role played by health products[1] and services innovation in bringing new treatments and value to patients and health care systems around the world;

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

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

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

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

Taking note of the productive discussions at the second Fair Pricing Forum (Johannesburg, South Africa, 11–13 April 2019) regarding the promotion of greater transparency around prices of health

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

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

[3] Document A72/17.

[4] Document EB144/18.

products, especially through sharing of information to stimulate the development of functional and competitive global markets;

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

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

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

Agreeing that policies that influence the pricing of health products and that reduce barriers to access can be better formulated and evaluated when there are reliable, comparable, transparent and sufficiently detailed data[1] across the value chain,

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

(1) to take appropriate measures to publicly share information on the net prices[2] of health products;

(2) to take the necessary steps, as appropriate, to support dissemination and enhanced availability of, and access to, aggregated results data and, if already publicly available or voluntarily provided, costs from human subject clinical trials regardless of outcomes or whether the results will support an application for marketing approval, while ensuring patient confidentiality;

(3) to work collaboratively to improve the reporting of information by suppliers on registered health products, such as reports on sales revenues, prices, units sold, marketing costs, and subsidies and incentives;

(4) to facilitate improved public reporting of patent status information and the marketing approval status of health products;

(5) to improve national capacities in the area of health products, including through international cooperation and open and collaborative research and development and production of health products, especially in developing countries and low- and middle-income countries, including health products for the diseases that primarily affect them, as well as capacities for product selection, cost-effective procurement, quality assurance, and supply chain management;

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

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

2. REQUESTS the Director-General to:

(1) to continue to support Member States, upon their request, in collecting and analysing information on economic data across the value chain for health products and data for relevant policy development and implementation towards achieving universal health coverage;

(2) to continue supporting Member States, especially low- and middle-income countries, in developing and implementing their national policies relevant to the transparency of markets for health products, including national capacities for local production, rapid and timely adoption of generic and biosimilar products, cost-effective procurement, product selection, quality assurance and supply-chain management of health products;

(3) to support research on price transparency and monitor its impact on affordability and availability of health products, including its effect on differential pricing, especially in low- and middle-income countries and small markets, and provide analysis and support to Member States in this regard as appropriate;

(4) to analyse the availability of data on inputs throughout the value chain, including data on clinical trials and price information, with a view to assessing the feasibility and potential value of establishing a web-based tool to share information relevant to the transparency of markets for health products, including information on investments, incentives, and subsidies;

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

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

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

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

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

The Seventy-second World Health Assembly,

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

[1] Document A72/37.

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

Noting that, at the time of opening of the Seventy-second World Health Assembly, the voting rights of the Central African Republic,[2] Comoros, Gambia, Guinea-Bissau, South Sudan, Ukraine, and Venezuela (Bolivarian Republic of)[3] were suspended, such suspension to continue until the arrears of the Member States concerned have been reduced, at the present or future Health Assemblies, to a level below the amount that would justify invoking Article 7 of the Constitution;

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

DECIDES:

(1) that, in accordance with the statement of principles set out in resolution WHA41.7 (1988), if, by the time of the opening of the Seventy-third World Health Assembly, Congo and Senegal are still in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution, their voting privileges shall be suspended as from the said opening;

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

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

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

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

The Seventy-second World Health Assembly,

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

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

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

[1] Document A72/66.

[2] See document A72/61.

[3] See document A72/60 Rev.1.

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

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

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

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

4. FURTHER REQUESTS the Director-General to communicate this resolution to the Government of the Central African Republic.

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

WHA72.11 Appointment of the External Auditor

The Seventy-second World Health Assembly,

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

1. RESOLVES that the Comptroller and Auditor General of India shall be appointed External Auditor of the accounts of the World Health Organization for the four-year period from 2020 to 2023 and that he/she shall audit in accordance with the principles incorporated in Regulation XIV of the Financial Regulations and the Appendix to the Financial Regulations, and that, should the necessity arise, he/she may designate a representative to act in his/her absence;

[1] Document A72/42.

2. EXPRESSES its thanks to the Commission on Audit of the Republic of the Philippines for the work it has performed for the Organization in auditing the accounts for the eight-year period from 2012 to 2019.

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

WHA72.12 Scale of assessments for 2020–2021

The Seventy-second World Health Assembly,

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

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 A72/38.

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

Members and Associate Members	WHO scale for 2020–2021 %
Netherlands	1.3561
New Zealand	0.2910
Nicaragua	0.0050
Niger	0.0020
Nigeria	0.2500
Niue (not a member of the United Nations)	0.0010
North Macedonia	0.0070
Norway	0.7540
Oman	0.1150
Pakistan	0.1150
Palau	0.0010
Panama	0.0450
Papua New Guinea	0.0100
Paraguay	0.0160
Peru	0.1520
Philippines	0.2050
Poland	0.8021
Portugal	0.3500
Puerto Rico (not a member of the United Nations)	0.0010
Qatar	0.2820
Republic of Korea	2.2671
Republic of Moldova	0.0030
Romania	0.1980
Russian Federation	2.4052
Rwanda	0.0030
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

Members and Associate Members	WHO scale for 2020–2021 %
Sudan	0.0100
Suriname	0.0050
Sweden	0.9061
Switzerland	1.1511
Syrian Arab Republic	0.0110
Tajikistan	0.0040
Thailand	0.3070
Timor-Leste	0.0020
Togo	0.0020
Tokelau (not a member of the United Nations)	0.0010
Tonga	0.0010
Trinidad and Tobago	0.0400
Tunisia	0.0250
Turkey	1.3711
Turkmenistan	0.0330
Tuvalu	0.0010
Uganda	0.0080
Ukraine	0.0570
United Arab Emirates	0.6160
United Kingdom of Great Britain and Northern Ireland	4.5673
United Republic of Tanzania	0.0100
United States of America	22.0000
Uruguay	0.0870
Uzbekistan	0.0320
Vanuatu	0.0010
Venezuela (Bolivarian Republic of)	0.7280
Viet Nam	0.0770
Yemen	0.0100
Zambia	0.0090
Zimbabwe	0.0050
Total	**100.0000**

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

WHA72.13 Salaries of staff in ungraded positions and of the Director-General[1]

The Seventy-second World Health Assembly,

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

1. ESTABLISHES the salaries of Assistant Directors-General and Regional Directors at US$ 179 948 gross per annum with a corresponding net salary of US$ 134 266;

2. ESTABLISHES the salary of the Deputy Directors-General at US$ 198 315 gross per annum with a corresponding net salary of US$ 146 388;

3. ESTABLISHES the salary of the Director-General at US$ 244 571 gross per annum with a corresponding net salary of US$ 176 917;

4. DECIDES that those adjustments in remuneration shall take effect from 1 January 2019.

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

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

The Seventy-second World Health Assembly,

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

Having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-second World Health Assembly;[4]

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

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

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

[2] See document A72/45.

[3] See document A72/60 Rev.1.

[4] Document A72/66.

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

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

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

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

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

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

WHA72.15 Eleventh revision of the International Classification of Diseases[1]

The Seventy-second World Health Assembly,

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

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

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

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

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

(1) the detailed list of four-character categories and optional five- and six-character subcategories[5] with the short tabulation lists for mortality and morbidity;

(2) the definitions, standards and reporting requirements related to maternal, fetal, perinatal, neonatal and infant mortality;[6]

(3) the rules and instructions for underlying cause coding for mortality and main condition coding for morbidity;

2. REQUESTS the Director-General:

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

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

[2] Documents A72/29 and A72/29 Add.1.

[3] Resolution WHA20.18.

[4] Resolution WHA43.24.

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

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

(2) to publish the ICD-11 in the six official languages of the Organization and put in place the digital tools and support mechanisms for its maintenance, dissemination and use, including facilitation of linkages with existing clinical terminologies;

(3) to provide support upon request to Member States in implementing ICD-11, including in building systems and capacity, and by providing the ICD-11 translation platform;

(4) to provide transitional arrangements from 1 January 2022 for at least five years, and as long as necessary to enable Member States to compile and report statistics using previous revisions of the International Classification of Diseases;

(5) to implement a regular updating process for ICD-11,[1] and to further develop and implement the family of disease- and health-related classifications, with the International Statistical Classification of Diseases and Related Health Problems as the core classification linked to other related classifications, specialty versions and terminologies;

(6) to report on progress in implementing this resolution to the Seventy-sixth World Health Assembly in 2023, the Eightieth World Health Assembly in 2027, and the Eighty-fifth World Health Assembly in 2032, and to include in the 2032 report an assessment of the need for revision of ICD-11.

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

WHA72.16 Emergency care systems for universal health coverage: ensuring timely care for the acutely ill and injured[2]

The Seventy-second World Health Assembly,

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

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

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

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

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

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

[3] Document A72/31.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. URGES Member States:[2]

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

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

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

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

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

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

(5) to promote more coherent and inclusive approaches to safeguard effective emergency care systems as a pillar of universal health coverage in fragile situations and conflict-affected areas, ensuring the continuum and provision of essential health services, and public health functions, in line with humanitarian principles;

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

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

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

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

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

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

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

3. REQUESTS the Director-General:

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

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

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

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

(4) to renew efforts outlined in resolution WHA60.22 to provide support to Member States, upon request, for needs assessments, facility inspection, quality- and safety-improvement programmes, review of legislation, and other aspects of strengthening the provision of emergency care;

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

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

(7) to facilitate awareness and international and domestic resource mobilization, in line with the Addis Ababa Action Agenda of the Third International Conference on Financing for Development[1] by providing advocacy resources;

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

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

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

DECISIONS

WHA72(1) Composition of the Committee on Credentials

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

2. (First plenary meeting, 20 May 2019)

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

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

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

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

(First plenary meeting, 20 May 2019)

WHA72(3) Election of officers of the main committees

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

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

(First plenary meeting, 20 May 2019)

The main committees subsequently elected the following officers:

Committee A:	**Vice-Chairmen**	Dr Yasuhiro Suzuki (Japan) Dr Mohammad Assai Ardakani (Islamic Republic of Iran)
	Rapporteur	Ms Laura Bordón (Paraguay)
Committee B:	**Vice-Chairmen**	Dr Karen Gordon-Campbell (Guyana) Mr Abdulla Ameen (Maldives)
	Rapporteur	Dr Ahmad Jan Naeem (Afghanistan)

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

WHA72(4) Establishment of the General Committee

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

(First plenary meeting, 20 May 2019)

WHA72(5) Adoption of the agenda

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

(Second plenary meeting, 20 May 2019)

WHA72(6) Verification of credentials

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

(Fifth plenary meeting, 22 May 2019)

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

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

(Sixth plenary meeting, 24 May 2019)

WHA72(8) Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan[1]

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

(1) to report on progress in the implementation of the recommendations contained in the report by the Director-General, based on field monitoring, to the Seventy-third World Health Assembly;

(2) to provide support to the Palestinian health services, including through capacity-building programmes and the development of strategic plans for investments in specific treatment and diagnostic capacities locally;

(3) to ensure sustainable procurement of WHO prequalified vaccines and medicine, and medical equipment, to the occupied Palestinian territory in compliance with international humanitarian law and WHO norms and standards;

(4) to provide health-related technical assistance to the Syrian population in the occupied Syrian Golan;

(5) to continue providing the necessary technical assistance in order to meet the health needs of the Palestinian people, including prisoners and detainees, in cooperation with the efforts of the International Committee of the Red Cross, as well as the health needs of handicapped and injured people;

(6) to support the development of the health system in the occupied Palestinian territory, including east Jerusalem, by: focusing on the development of human resources, in order to localize health services, decreasing referrals and reducing cost; strengthening provision of mental health services; and maintaining strong primary health care with integrated complete appropriate health services;

(7) to ensure the allocation of human and financial resources in order to achieve these objectives.

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

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

[2] Document A72/33.

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

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

(1) to note the WHO global strategy on health, environment and climate change;[2]

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

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

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

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

(1) to note the plan of action on climate change and health in small island developing States;[4]

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

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

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

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

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[1] Document A72/15.

[2] See Annex 2.

[3] See document A72/16.

[4] See Annex 3.

[5] Document A72/19.

(1) to welcome the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases adopted by the United Nations General Assembly in resolution 73/2 (2018), and to request the Director-General to provide support to Member States in its implementation;

(2) to confirm the objectives of WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2020 and WHO's comprehensive mental health action plan 2013–2020 as a contribution towards the achievement of Sustainable Development Goal target 3.4 (by 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being) and other noncommunicable disease-related goals and targets, and to extend the period of the action plans to 2030 in order to ensure their alignment with the 2030 Agenda for Sustainable Development;

(3) to request the Director-General:

(a) to propose updates to the appendices of WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2020 and WHO's comprehensive mental health action plan 2013–2020, as appropriate, in consultation with Member States and taking into account the views of other stakeholders,[1] ensuring that the action plans remain based on scientific evidence for the achievement of previous commitments for the prevention and control of noncommunicable diseases, including Sustainable Development Goal target 3.4 (by 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being) and other related goals and targets;

(b) building on the work already under way, to prepare and update, as appropriate, a menu of policy options and cost-effective interventions to support Member States in implementing the commitments included in the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases (2018) to promote mental health and well-being, for consideration by the Seventy-third World Health Assembly in 2020, through the Executive Board;

(c) building on the work already under way, to prepare a menu of policy options and cost-effective interventions to provide support to Member States in implementing the commitments included in the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases (2018) to reduce the number of premature deaths from noncommunicable diseases attributed to air pollution, while recognizing the importance of addressing all environmental determinants, for consideration by the Seventy-third World Health Assembly in 2020, through the Executive Board;

(d) to report to the Seventy-third World Health Assembly in 2020, through the Executive Board, on the implementation of WHO's global strategy to reduce the harmful use of alcohol during the first decade since its endorsement, and the way forward;

(e) to consolidate reporting on the progress achieved in the prevention and control of noncommunicable diseases and the promotion of mental health with an annual report to be submitted to the Health Assembly through the Executive Board, from 2021 to 2031,

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

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

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

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

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

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

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

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

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

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

WHA72(12) Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits[1]

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

(1) to request the Director-General:

(a) to work with the Global Influenza Surveillance and Response System (GISRS) and other partners, such as Other Authorized Laboratories and relevant institutions, to collect, analyse, and present data on influenza virus sharing in a way that enables a deeper understanding of the challenges, opportunities and implications for public health associated with virus sharing under the GISRS, including by identifying: specific instances where influenza virus sharing has been hindered; and how such instances may be mitigated;

(b) to prepare a report, with inputs from Member States[4] and stakeholders, as appropriate, on the treatment of influenza virus sharing and the public health considerations thereof by existing relevant legislation and regulatory measures, including those implementing the Nagoya Protocol, in consultation with the Secretariat of the Convention on Biological Diversity as appropriate;

(c) to provide more information on the functioning, usefulness and limitations of the prototype search engine;

(d) to explore, including through soliciting input from Member States, possible next steps in raising awareness of the PIP Framework among relevant databases and initiatives, data providers and data users, and in promoting the acknowledgment of data providers and collaboration between data providers and data users;

(e) to continue providing information on new challenges posed and opportunities provided by new technologies in the context of the PIP Framework for the sharing of influenza viruses and access to vaccines and other benefits and possible approaches to them;

(2) to revise Footnote 1 in the Standard Material Transfer Agreement 2 (SMTA2), in Annex 2 to the PIP Framework, as set out in Annex 4, B with effect from the closure of the Seventy-second World Health Assembly;

(3) to further request the Director-General to report on implementation of the foregoing to the Seventy-third World Health Assembly in 2020, through the Executive Board at its 146th session.

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

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

[2] Documents A72/21 and A72/21 Add.1.

[3] See Annex 4, A.

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

WHA72(13) The public health implications of implementation of the Nagoya Protocol[1]

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

(1) to provide information on current pathogen-sharing practices and arrangements, the implementation of access and benefit-sharing measures, as well as the potential public health outcomes and other implications; and

(2) to provide a report to the Seventy-fourth World Health Assembly, through the Executive Board at its 148th session, as well as an interim report to the Executive Board at its 146th session.

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

WHA72(14) Promoting the health of refugees and migrants

The Seventy-second World Health Assembly, having considered the report on promoting the health of refugees and migrants[3] decided:

(1) to take note of the WHO global action plan on promoting the health of refugees and migrants, 2019–2023;[4]

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

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

WHA72(15) Report of the External Auditor

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

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

[2] Document A72/32.

[3] Document A72/25 Rev.1.

[4] See Annex 5.

[5] Document A72/39.

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

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

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

The Seventy-second World Health Assembly, having considered the WHO Results Report for the Programme budget 2018–2019: mid-term review[2] and the audited financial statements for 2018;[3] and having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-second World Health Assembly,[4] decided to accept the WHO Results Report for the Programme budget 2018–2019: mid-term review and the audited financial statements for 2018.

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

WHA72(17) Human resources: annual report

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

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

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

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

[1] Document A72/67.

[2] Document A72/35

[3] Documents A72/36 and A72/INF./5.

[4] Document A72/62.

[5] Document A72/43.

[6] Document A72/65.

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

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

WHA72(19) 2020: International Year of the Nurse and the Midwife[1]

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

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

WHA72(20) World Chagas Disease Day[1]

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

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

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

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

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

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

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

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

[2] Document A72/50.

[3] See Annex 7.

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

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

(1) to amend Rules 5, 11, and 12 of the Rules of Procedure of the World Health Assembly as set out in Annex 8, in accordance with Rule 119 of the Rules of Procedure of the World Health Assembly, with effect from the closure of its Seventy-second session; and to recommend that the explanatory memorandum referred to in the third paragraph of Rule 5 of the Rules of Procedure of the World Health Assembly, as amended, be limited to 500 words;

(2) to amend Rule 48 of the Rules of Procedure of the World Health Assembly as set out in Annex 8, in accordance with Rule 119 of the Rules of Procedure of the World Health Assembly, with effect from the closure of its Seventy-second session;

(3) to amend the definitions at the beginning of the Rules of Procedure of the World Health Assembly, Rules 3, 14, 19, 22, the heading between Rule 43 and Rule 44, and Rule 47 of the Rules of Procedure of the World Health Assembly as set out in Annex 8, in accordance with Rule 119 of the Rules of Procedure of the World Health Assembly, with effect from the closure of its Seventy-second session;

(4) that resolutions and decisions should provide for clear reporting requirements, including reporting cycles of up to six years, with biennial reports, unless otherwise advised by the Director-General.

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

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

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

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

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

[2] Document A72/51.

[3] Document A72/52.

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

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

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

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

(Seventh plenary meeting, 28 May 2019)

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