

PROVISIONAL SUMMARY RECORD OF THE FIFTH MEETING

**WHO headquarters, Geneva
Wednesday, 1 February 2023, scheduled at 10:00**

Chair: Dr K. V. PETRIČ (Slovenia)

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FIFTH MEETING

Wednesday, 1 February 2023, at 10:00

Chair: Dr K. V. PETRIČ (Slovenia)

PILLAR 2: ONE BILLION MORE PEOPLE BETTER PROTECTED FROM HEALTH EMERGENCIES

1. PUBLIC HEALTH EMERGENCIES: PREPAREDNESS AND RESPONSE: Item 12 of the agenda (continued)

Strengthening WHO preparedness for and response to health emergencies: Item 12.1 of the agenda (continued)

- **Strengthening the global architecture for health emergency preparedness, response and resilience** (document EB152/12) (continued)

The Observer of PALESTINE, speaking on a point of order, expressed regret that Observers had not been included in the trial practice of allowing constituency statements by non-State actors to be interspersed among those made by Member States not represented on the Board. Including Observers in that positive, inclusive practice would improve transparency and enable the Secretariat to take the views of all participants into consideration.

Turning to the document under discussion, he welcomed the 10 proposals for strengthening the global architecture for health emergency preparedness, response and resilience. It was important to strengthen transparency and equity in order to build trust among local authorities and between local authorities and WHO to improve collaboration, as part of the overall aim of strengthening capacity to effectively manage health emergencies.

The representative of the ISLAMIC REPUBLIC OF IRAN¹ expressed support for WHO's role as a Member State-led organization at the centre of the global architecture for health emergencies, underscoring the importance of equity as an overarching principle in efforts to guarantee access to medical countermeasures. Further inclusive discussions were required at the Member State level to fully assess the proposals. In relation to proposal 3 on scaling up the Universal Health and Preparedness Reviews and strengthening independent monitoring, it was important to ensure that such processes were implemented on a voluntary basis. Lastly, he noted that the services provided by WHO country offices were most effective when delivered within the framework of national policies and priorities.

The observer of GAVI, THE VACCINE ALLIANCE stressed the need to strengthen routine immunization, particularly among vulnerable communities, in order to rapidly respond to threats and avoid disruption during emergencies. Coordination initiatives should incorporate meaningful country engagement and reflect the global, interconnected nature of health threats, with a networked approach to ensure that health emergency processes were inclusive. Long-term, agile financing was also needed to ensure rapid access to vaccines and other medical countermeasures; financing plans should be developed alongside governance processes to guarantee their sustainability.

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of IOM welcomed the steps taken thus far to strengthen the global architecture for health emergencies, notably the commitment to equity, inclusivity and coherence. Her Organization's own contribution to the discussions on a new WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response (pandemic accord) focused on supporting Member States to facilitate human mobility within pandemic preparedness and response, and ensuring that migrants had equitable access to health services, including in health emergencies. IOM supported the three pillars of the global health emergency preparedness, response and resilience architecture and welcomed the commitment to strengthening the core capacities required by the International Health Regulations (2005) through the further development of national action plans for health security and the Universal Health and Preparedness Reviews. Migration should be taken into account as a key social determinant in that regard.

The representative of IAEA stressed the need for collaboration and innovative tools to support veterinary laboratories in tackling outbreaks at the animal-human interface. To that end, the IAEA Zoonotic Disease Integrated Action initiative aimed to improve the capabilities of Member States to respond to the threat of zoonotic diseases by building resilient laboratory networks. IAEA would continue to work closely with WHO, FAO and WOAHA on a range of research projects to promote better preparedness for and response to health emergencies.

The representative of the INTERNATIONAL DEVELOPMENT LAW ORGANIZATION drew attention to the need to strengthen national legal frameworks to improve health emergency preparedness and enable Member States to implement their commitments under the International Health Regulations (2005) and any future pandemic instruments. It was also vital to bolster national and civil society capacity to understand the role of the law with regard to public health emergency preparedness and response.

The representative of the MEDICINES PATENT POOL FOUNDATION, speaking at the invitation of the CHAIR, welcomed the proposals and noted the emphasis placed on the need to expand partnerships and strengthen networks for a whole-of-society approach to ensuring access to medical countermeasures. In the light of the crucial role that collaboration had played in the COVID-19 response, he supported a framework that would harness collaborative mechanisms to address inequities in access to medical countermeasures.

The representative of HELPAGE INTERNATIONAL, speaking at the invitation of the CHAIR, said that the COVID-19 pandemic had highlighted the brutal consequences of infectious diseases for older persons and other at-risk populations. Age discrimination should be explicitly prohibited in emergency responses and in any future pandemic accord, and measures should be taken to ensure the engagement and empowerment of older people at all levels.

The representative of the EUROPEAN SOCIETY FOR MEDICAL ONCOLOGY, speaking at the invitation of the CHAIR, said that there was a need to provide health care professionals with ethical and methodological guidelines on decision-making to ensure the best possible outcomes where resources were scarce. In addition, action plans should be developed to address the needs of vulnerable patients who were unable to access health services during health emergencies. Civil society resources should also be leveraged with a view to minimizing the risks to cancer patients during health emergencies.

The representative of the DRUGS FOR NEGLECTED DISEASES INITIATIVE, speaking at the invitation of the CHAIR, said that greater coordination was needed to ensure equitable access to new treatments and technologies. In particular, research and development should be prioritized to ensure it was inclusive of communities and covered climate-sensitive and epidemic-prone diseases. An open,

end-to-end approach to innovation was needed to facilitate the sharing of knowledge, data and intellectual property, and to guarantee rapid progression to clinical trials, with related capacities mapped and expanded in all regions. Globally linked research infrastructure would provide the necessary flexibility to address both pandemics and existing health priorities, while financing mechanisms for research and development should ensure that new treatments and technologies were available for all.

The representative of the WORLD FEDERATION OF HEMOPHILIA, speaking at the invitation of the CHAIR, drew attention to the disruptions in treatment faced by many people living with inherited bleeding disorders as a result of the COVID-19 pandemic. In its work to strengthen health emergency preparedness and response, WHO should promote more equitable access to prophylaxis and home therapy for people living with bleeding disorders, as that would allow for optimal care while reducing the burden on emergency wards and minimizing those people's exposure to pathogens.

The representative of ALZHEIMER'S DISEASE INTERNATIONAL, speaking at the invitation of the CHAIR, expressed support for the 10 proposals. He urged Member States to be mindful of, and take action to reduce, the impact of health emergencies on older persons, especially those living with dementia, who had often been excluded from treatment during the COVID-19 pandemic due to a lack of preparedness within health systems.

The representative of MEDICUS MUNDI INTERNATIONAL – NETWORK HEALTH FOR ALL, speaking at the invitation of the CHAIR, said that greater coherence was required in the design of the global architecture for health emergency preparedness, response and resilience before the proposals were taken forward. The document failed to clarify the framework for community-based primary health care as a vital part of health system preparedness and did not acknowledge the health worker shortage affecting both developing and developed countries; WHO should address those systemic issues before institutionalizing a global health emergency corps. Furthermore, caution should be exercised regarding the increased involvement of international financial institutions in global health governance, as the lending conditions imposed by such institutions negatively impacted the health of vulnerable populations and drove developing countries into debt. WHO should instead explore financing mechanisms that would break those dynamics. It should also produce guidelines to encourage local leadership of trials and robust data- and benefit-sharing arrangements, ensuring that interventions were acceptable and accessible to trial populations.

The representative of THE ROYAL COMMONWEALTH SOCIETY FOR THE BLIND – SIGHTSAVERS, speaking at the invitation of the CHAIR, welcomed the proposed framework to strengthen the global architecture for health emergency preparedness, response and resilience, particularly the principles of equity, inclusivity and coherence. It was also positive to see an emphasis on building national capacities that ensured accountability towards communities and that advanced equity and human rights. She called on Member States to ensure that the advancement of equity within the new global architecture included the targeted and adapted measures needed to guarantee non-discrimination and the right to health for disadvantaged and at-risk groups, including persons with disabilities.

The representative of the INTERNATIONAL BABY FOOD ACTION NETWORK, speaking at the invitation of the CHAIR, said that breastfeeding was a resilient practice that could provide a lifeline during emergencies. However, it continued to come under attack from manufacturers of ultra-processed foods, which should only be used as a last resort and where appropriate support was provided. Preparedness plans should therefore take into account the operational guidance provided by the Infant Feeding in Emergencies Core Group and incorporate conflict of interest safeguards.

The REGIONAL DIRECTOR FOR AFRICA, observing that global health crises affected all segments of society, said that the COVID-19 pandemic had underscored the importance of investing in strong health systems to prepare for and respond to emergencies, while maintaining essential health service delivery. Any initiatives undertaken in that respect should take into consideration the critical role of primary health care and universal health coverage in ensuring equitable access to services and safeguarding communities from future threats. It was also vital to address shortages in the health workforce – which in the African Region were notably caused by brain drain – and redefine the role of communities in public health emergencies. Primary health care represented the first point of contact with the health care system for over 80% of the population in the African Region and provided a direct link to communities.

All Member States in the Region had undergone joint external evaluations of the core capacities required by the International Health Regulations (2005) and developed national action plans for health security and were therefore ready to take action once sufficient financing was in place. Member States were being supported in the implementation of the new regional strategy for health security and emergencies through the Regional Office's emergency preparedness and response flagship projects, which included measures to strengthen the health workforce, national leadership, community participation and sustainable financing.

In the South-East Asia Region, nine of the 11 Member States had completed joint external evaluations of the core capacities required by the International Health Regulations (2005) and strengthened their national action plans for health security. The regional strategic road map on health security and health system resilience for emergencies 2023–2027 had been endorsed by the Regional Committee and would be implemented alongside the flagship priority programme on emergency risk management. In addition, the Asia Pacific Strategy for Emerging Diseases and Public Health Emergencies continued to guide Member States' efforts to implement the International Health Regulations (2005) in the South-East Asia and Western Pacific Regions, and a bi-regional health security action framework incorporating lessons learned from the COVID-19 pandemic and other health emergencies was being developed in consultation with Member States, partners and experts.

As the COVID-19 recovery continued, new challenges were arising that could only be addressed by improving primary health care and working with other sectors, such as water and sanitation. She therefore looked forward to working with Member States to take coordinated action on pandemic preparedness and response and to continue advocating for health as a pillar of sustainable development and security.

The EXECUTIVE DIRECTOR (WHO Health Emergencies Programme) thanked Member States for their comments. As speakers had noted, each country faced a unique set of threats and vulnerabilities, in terms of both their populations and the systems designed to protect them. WHO was responding to an unprecedented number of graded public health emergencies, with over 339 million people requiring urgent humanitarian assistance worldwide. Although there was no single system suitable for every context, it was possible to combine key components relating to governance, financing, tools and the health workforce within a single framework. Such a framework was not intended to interfere with any intergovernmental processes but would enable a bottom-up approach to improving global health security. That should begin with empowered, protected communities supported by effective primary health care functions that were on the front line of pandemic protection and include participatory surveillance systems capable of detecting any threats. Clinical care systems also needed to be agile and scalable to react to the stress of a health emergency without undermining other key health system components, as had occurred during the COVID-19 pandemic. In turn, those systems needed to be underpinned by national, regional and global coordination mechanisms, governance and financing. The five core systems described in the report had been identified with that in mind. National action plans for health security, informed by evaluations such as the State Party self-assessment annual reporting tool, would be central to that work. Indeed, a global or regional response would be impossible without action at the national level, and the expertise and experience of Member States was key to global health

security. To that end, the Secretariat would support Member States and facilitate the operational discussions that would feed into the deliberations of the Intergovernmental Negotiating Body to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response. It was important to place Member States and their national security at the centre of solutions. WHO would play a vital coordination role – as it had done during the COVID-19 pandemic, when low- and middle-income countries had been able to receive personal protective equipment and other medical supplies through a supply chain system managed by the Organization. However, such systems would be built collectively and transparently, with the full involvement of Member States.

The ASSISTANT DIRECTOR-GENERAL (Health Emergency Intelligence and Surveillance Systems in the Emergencies Programme) noted the comments concerning the importance of ensuring equity and the need to learn lessons from the COVID-19 pandemic. It was positive to see general consensus regarding the five core systems outlined in the report, as they would govern the delivery of services at the national level. He looked forward to working with and learning from Member States and other partners in taking the next steps to develop the proposals further.

The DIRECTOR-GENERAL thanked Member States for their input. He stressed that, in undertaking work on several processes at once, there was no intention of undermining the process of amending the International Health Regulations (2005) or the work of the Intergovernmental Negotiating Body; rather, the aim was to maintain momentum on the issue of health emergency preparedness, response and resilience by making progress on several fronts at the same time. That work would continue in full transparency with a view to achieving the best health outcomes.

The CHAIR took it that the Board wished to note the report contained in document EB152/12.

The Board noted the report.

PILLAR 4: MORE EFFECTIVE AND EFFICIENT WHO PROVIDING BETTER SUPPORT TO COUNTRIES

2. COMMITTEES OF THE EXECUTIVE BOARD: Item 24 of the agenda

Standing Committee on Health Emergency Prevention, Preparedness and Response: Item 24.3 of the agenda (documents EB152/45, EB152/54 and EB152/54 Add.1)

The CHAIR invited the Board to consider the reports contained in documents EB152/45 and EB152/54, as well as the three options for addressing the misalignment between the terms of membership of the Standing Committee and the normal schedule of WHO committee membership set out in paragraphs 5 to 10 of document EB152/54 and the options for a related draft decision contained in paragraph 11 of that document. The financial and administrative implications of the proposed options for a draft decision were contained in document EB152/54 Add.1.

The representative of RWANDA, speaking on behalf of the Member States of the African Region, welcomed the reports and expressed strong support for first option proposed for the draft decision, which would ensure a balance between continuity and the regular rotation of membership among Member States.

The representative of PARAGUAY agreed that option 1 was the best solution for the same reasons.

The representative of PERU welcomed the establishment of the Standing Committee, which would provide rapid support to WHO in the event of a public health emergency, and similarly expressed a preference for option 1.

The representative of the RUSSIAN FEDERATION expressed concern that no Member States from the Commonwealth of Independent States were represented on the Standing Committee, particularly given the importance of regional representation within WHO committees in the context of preventing and responding to communicable diseases. Option 2 was the only correct approach to addressing the misalignment in the terms of membership of the Standing Committee, as it would provide for the expiry of the terms of its members, Chair and Vice-Chair in accordance with the terms of reference. Option 1 went against the terms of reference and would therefore create an unacceptable precedent in that regard.

The representative of the UNITED STATES OF AMERICA welcomed the establishment of the Standing Committee and stressed the importance of ensuring that the WHO Health Emergencies Programme could effectively play the central coordinating role entrusted to it by Member States. She supported option 1.

The representative of DENMARK, speaking on behalf of the European Union and its Member States, said that the candidate countries North Macedonia, Montenegro, Albania, Ukraine, the Republic of Moldova and Bosnia and Herzegovina aligned themselves with his statement. The establishment of the Standing Committee should strengthen WHO's central role within the global health security architecture, and the possibility of calling on relevant experts represented an opportunity to strengthen links at the regional level, including with the WHO regional offices. It would also be important for the Standing Committee to establish links with other bodies, such as the One Health High-Level Expert Panel and the quadripartite partnership, to ensure a fully operational One Health approach to health emergency prevention, preparedness and response. He supported option 1.

The representative of CANADA refrained from expressing an opinion on the three options for addressing misalignment between the terms of membership of the Standing Committee and the normal schedule of WHO committee membership, as his delegation would be directly impacted by any decision. His Government strongly supported the establishment of the Standing Committee, which provided an important space for debate and discussion on health emergency prevention, preparedness and response, and to strengthen engagement with, and oversight of, the Health Emergencies Programme. It would also help strengthen the Executive Board's governance capacity by giving Member States a more agile mechanism to provide guidance to the Board and advise the Director-General. Outside emergency situations, the Standing Committee would allow for more in-depth discussions on reinforcing the WHO Health Emergencies Programme, including by reviewing its reports, notably regarding the Contingency Fund for Emergencies, and the recommendations of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme. The next meeting of the Standing Committee would be critical to building a strong foundation for that vital function.

The representative of BRAZIL welcomed the establishment of the Standing Committee and called for its work to be guided by the principle of equity. It was particularly important to promote the local and regional production of health technologies in order to address the stark disparities in access to countermeasures observed during the COVID-19 pandemic, which had particularly affected developing countries. A whole-of-government approach and multistakeholder engagement were also essential to pandemic prevention, preparedness and response at the local, national, regional and international levels.

His Government looked forward to learning how the Standing Committee would carry out its work in accordance with its terms of reference, particularly during a public health emergency of international concern. That work should be based on scientific evidence, take into account the needs expressed by Member States affected by health emergencies and remain complementary to existing processes, particularly those concerning amendments to the International Health Regulations (2005) and any future pandemic accord. Regarding the terms of membership, he supported option 1.

The representative of JAPAN stressed the importance of strengthening governance within WHO in order to enhance the Organization's capacity to prepare for and respond to health emergencies. The Standing Committee should focus on the administrative aspects of such issues, including by addressing the financial and human resource burdens that might restrict the actions of the Director-General during a health emergency. The membership terms of the Standing Committee should be aligned with the schedule of the Health Assembly; his Government therefore supported option 1, which would also ensure a balance between the continuity and regular rotation of membership among Member States.

The representative of MALDIVES stressed that the mandate of the Standing Committee should be complementary to existing mechanisms to avoid any risk of duplication of efforts. It was also important to ensure continuity in the Standing Committee's work and he therefore supported option 1.

The representative of YEMEN, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the Standing Committee had the potential to make important contributions to global health security and health emergency management. The COVID-19 pandemic had shown that the global community had not been ready for a crisis on that scale. Of the recommendations from numerous reviews of the global COVID-19 response, it was striking that more than half related to the need to improve the governance of health emergency prevention, preparedness and response mechanisms, at all levels. As it carried out its duties in line with the terms of reference, the Standing Committee should consult with the Independent Oversight Advisory Committee for the WHO Health Emergencies Programme, and more details should be provided on its linkages with other WHO technical and advisory committees. The Member States of the Region were committed to supporting the work of the Standing Committee and had a preference for option 1.

The representative of MALAYSIA commended the work of the Standing Committee at its first meeting, stressing the need for the Standing Committee to complement other processes as well as for cooperation in efforts to address gaps in the management of health emergencies.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND reiterated her Government's support for the creation of the Standing Committee and its dual mandate to act swiftly in response to a public health emergency of international concern and help to strengthen the oversight of the WHO Health Emergencies Programme. The Standing Committee would also play an important role in improving governance, including by strengthening the Executive Board. She supported option 1.

The representative of CHINA expressed support for the work of the Standing Committee, stressing the need for a transparent and open approach that remained within the scope of the Committee's terms of reference. The Secretariat should provide the necessary support in that respect. Regarding the terms of membership, he supported option 1.

The representative of COLOMBIA welcomed the establishment of the Standing Committee, which should help to ensure that WHO governing bodies' decisions were consistent, equitable, effective

and informed by a balanced approach to scientific and political considerations. His Government favoured option 1.

The CHAIR asked whether the first option proposed for the draft decision could be adopted by consensus.

The representative of the RUSSIAN FEDERATION reiterated her support for option 2.

The representative of NORWAY¹ said that the Standing Committee would give Member States an opportunity for more regular, in-depth engagement on strengthening WHO's capacities during health emergencies, which should lead to a more sustained focus on and systematic follow-up of associated issues. It was especially important to ensure that the Standing Committee was able to support a strong, rapid WHO response during public health emergencies of international concern; it should therefore adhere strictly to its terms of reference. She favoured option 1 regarding the terms of membership.

The representative of SINGAPORE¹ expressed a preference for option 1.

The CHAIR suggested that consideration of the item should be suspended pending informal discussions.

It was so agreed.

(For continuation of the discussion and adoption of a decision, see the summary records of the sixth meeting, section 1.)

PILLAR 1: ONE BILLION MORE PEOPLE BENEFITING FROM UNIVERSAL HEALTH COVERAGE

3. UNIVERSAL HEALTH COVERAGE: Item 5 of the agenda

- **Reorienting health systems to primary health care as a resilient foundation for universal health coverage and preparations for a high-level meeting of the United Nations General Assembly on universal health coverage** (document EB152/5)

The CHAIR invited the Board to consider the report contained in document EB152/5 and to provide guidance on the specific priority areas for action based on the guiding questions set out in paragraph 35 of that document. She also drew attention to a draft decision on integrated emergency, critical and operative care for universal health coverage and protection from health emergencies proposed by Brazil, Ethiopia, the Member States of the European Union, Kenya and Paraguay, which read:

The Executive Board, having considered the report on re-orienting health systems to primary health care as a resilient foundation for universal health coverage,²

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

² Document EB152/5.

Decided to recommend to the Seventy-sixth World Health Assembly the adoption of the following resolution:

The Seventy-sixth World Health Assembly,

(PP1) Noting that emergency, critical and operative care services are an integral part of a comprehensive primary health care approach and are essential to ensure that the health needs of people are met across the life course without undue delay;

(PP2) Recognizing that robust emergency, critical and operative care services are at the foundation of national health systems' ability to respond effectively to emergency events including all hazards; and to ensure the implementation of the activities required, both proactive and reactive, to minimize the danger and impact of acute public health events;

(PP3) Concerned that the COVID-19 pandemic revealed pervasive gaps in capacity of emergency, critical and operative care services that resulted in significant avoidable mortality and morbidity globally;

(PP4) Noting that integrated people-centred service delivery requires emergency, critical and operative care services that are linked to communities through primary care and by communication, transportation, referral and counter-referral mechanisms,¹ and that these components are interdependent: capacity failures in responsiveness of the emergency, critical and operative care system may result in disrupted primary care delivery and poor outcomes, while failures in primary care and social services may lead to increased use of emergency, critical and operative care services and result in delays in the appropriate provision of life-saving care;

(PP5) Emphasizing that emergency, critical and operative care represents a continuum of services from the community to health centres to primary care clinics to hospitals, and that integrated planning and implementation of these services can lead to greater efficiency, effectiveness and deliver economies of scope and scale across disease and population-specific programmes;

(PP6) 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, critical and operative care is a key mechanism for achieving a range of associated targets – including those on universal health coverage (3.8), road safety (3.6), maternal and child health (3.1, 3.2), universal access to sexual and reproductive health-care services (3.7), noncommunicable diseases, mental health, and infectious disease (3.4, 3.5 and 3.3);

(PP7) 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-resourced system for emergency, critical and operative care embedded within the broader health system is vital to maintaining the continuity of essential health services in fragile and conflict-affected settings, and to mitigating the impact of disasters, outbreaks and mass casualty incidents, including those resulting from climate change;

¹ The term ECO-system is used here to refer to emergency, critical and operative care services and the mechanisms that ensure they are accessible to the people who need them. Bull World Health Organ 2020;98:728–728A | doi: <http://dx.doi.org/10.2471/BLT.20.280016>. Accessed 12 December 2022.

(PP8) Recalling the following resolutions in which the Health Assembly prioritized integrated service-delivery models and identified emergency, critical and operative care services as fundamental: 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, WHA68.15 (2015) on strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage, WHA69.1 (2016) on strengthening essential public health functions in support of the achievement of universal health coverage, WHA72.16 (2019) on emergency care systems for universal health coverage: ensuring timely care for the acutely ill and injured, and WHA74.7 (2021) on strengthening WHO preparedness for and response to health emergencies;

(PP9) Recognizing that emergency, critical and operative care services are necessary to execute the core capacities under the International Health Regulations (2005) and to promote the enjoyment of human rights;¹

(PP10) Recalling also the mandate of WHO's Thirteenth General Programme of Work, 2019–2023 to improve integrated service delivery, protect people from health emergencies and to serve in particular the most disadvantaged, marginalized and hard-to-reach populations, to ensure that no one is left behind;²

(PP11) Noting that providing non-discriminatory and equitable access for all people to timely, safe and high-quality emergency, critical and operative care services can contribute to the reduction of disparities in health outcomes, and that safe and effective patient flow is essential to protect people during emergencies;

(PP12) Emphasizing that timely access is an essential component of quality emergency, critical and operative care services and could prevent millions of deaths and long-term impairments from injuries, infections, mental health conditions, acute exacerbations of noncommunicable diseases, acute complications of pregnancy and other health conditions, including in neonates and children;

(PP13) Noting that injury alone accounts for nearly 5 million deaths per year and that road traffic injury is the top cause of death of all those in the age group of 5–29 years;³

¹ United Nations High Commissioner for Refugees. Convention and Protocol Relating to the Status of Refugees. UNHCR. 1951 (<http://www.unhcr.org/protection/basic/3b66c2aa10/convention-protocol-relating-status-refugees.html>, accessed 10 January, 2023).

Convention on the Elimination of All Forms of Discrimination against Women. U. N. Hum. Rights Off. High Comm. 1965 (<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CEDAW.aspx>, accessed 10 January, 2023).

Convention on cluster munitions 2008 (<https://www.un.org/disarmament/convention-on-cluster-munitions/>, accessed 10 January, 2023).

International Convention on the Elimination of All Forms of Racial Discrimination. U. N. Hum. Rights Off. High Comm. 1979 (<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CERD.aspx>, accessed 10 January, 2023).

Convention on the Rights of the Child. U. N. Hum. Rights Off. High Comm. 1989 (<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx>, accessed 10 January, 2023).

International Convention on the Protection of the Rights of All Migrant Workers. U. N. Hum. Rights Off. High Comm. 1990 (<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CMW.aspx>, accessed 10 January, 2023).

Convention on the prohibition of the use, stockpiling, production and transfer of Anti-personnel mines and on their destruction (<https://www.un.org/disarmament/anti-personnel-landmines-convention>, accessed 10 January, 2023).

² Thirteenth General Programme of Work, 2019–2023. Geneva: World Health Organization; 2018; as contained in document A71/4 (http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf?ua=1or, accessed 10 January 2023) and adopted in resolution WHA71.1.

³ Global Health Estimates, World Health Organization, 2019. <https://www.who.int/data/global-health-estimates> (accessed 10 January 2023).

and that most people affected by injury require access to emergency, critical and operative care services;

(PP14) Noting that emergency, critical and operative care interventions are effective and in general cost-effective, and concerned that the lack of investment in emergency, critical and operative care is compromising outcomes, limiting impact and increasing cost in other parts of the health system and potentially reducing impact of other health interventions;

(PP15) Noting that effective planning and resource allocation for delivery of emergency, critical and operative care requires understanding the potential and actual utilization of emergency, critical and operative care services, identifying and removing barriers to accessing care, and that it requires detailed analysis of data that is frequently unavailable or not recorded in many settings;

(PP16) Considering that quality emergency, critical and operative care services and improved outcomes are best guaranteed through ongoing monitoring to be used for service development, continuous quality improvement, targeted capacity building of the emergency, critical and operative care workforce and, as appropriate, through regulation;

(PP17) 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 and standards for essential emergency, critical and operative care services, equipment and supplies at each level of the health system,¹

(OP)1. CALLS FOR timely additional efforts globally to strengthen the planning and provision of emergency, critical and operative care services as part of universal health coverage, so as to meet population health needs, improve health system resilience and ensure public health security;²

(OP)2. URGES Member States in accordance with national context and priorities:³

(1) to create national policies for sustainable funding, effective governance (including coordination and regulation of public and private sector actors) and universal access to needs-based emergency, critical and operative care for all, without regard to sociocultural factors, without requirement for payment prior to life-saving emergency care, and within a broader health system that provides quality essential care and services and financial risk protection;

(2) to include emergency, critical and operative care services, with their associated rehabilitation services, across relevant health areas within national packages of services for universal health coverage, such as through use of the WHO UHC Service package delivery and implementation (SPDI) tool⁴ to identify relevant and feasible services and required resources based on national context;

(3) as appropriate, to conduct WHO emergency, critical and operative care system assessments⁵ to identify gaps and context-relevant action priorities, and to design

¹ Emergency care. Geneva: World Health Organization (see www.who.int/emergencycare, accessed 25 January 2023).

² Global public health security is defined as the activities required, both proactive and reactive, to minimize the danger and impact of acute public health events that endanger people's health across geographical regions and international boundaries (https://www.who.int/health-topics/health-security/#tab=tab_1, accessed 12 December 2022).

³ And, where applicable, regional economic integration organizations.

⁴ See www.uhcc.who.int (accessed 25 January 2023).

⁵ See who.int/emergency-care (accessed 25 January 2023).

and implement integrated national and/or regional action plans for emergency, critical and operative care;

(4) to integrate delivery of emergency, critical and operative care within relevant national health system assessments and strategies, including universal health coverage road maps, primary health care strategies, models of care, health emergency preparedness and response plans and National Action Planning for Health Security (NAPHS)¹ as appropriate;

(5) to develop national, sub-national and facility-level governance mechanisms for the coordination of routine prehospital and hospital-based emergency, critical and operative care services, patient transfer and referral services, including linkage with other relevant actors for disaster and outbreak preparedness and response;

(6) to promote more coherent, inclusive and accessible approaches to safeguard effective emergency, critical and operative care in disasters, fragile settings and conflict-affected areas, ensuring the continuum and provision of essential health services and public health functions, in line with international humanitarian law;

(7) to promote innovative ways for community engagement in the design and delivery of emergency, critical and operative care services, including community education on early recognition, care seeking, and first aid; training for community first aid responders (CFAR), such as the WHO CFAR programme; and structured mechanisms for incorporating community perspectives in strategic planning and monitoring of implementation;

(8) to promote access to timely and reliable prehospital care for all, including by establishing, where they do not exist, toll-free universal access numbers that meet international standards;

(9) to implement, as appropriate, key processes and protocols as identified in WHO guidance on delivery of emergency, critical and operative care, such as triage, checklists and the use of registries and clinical audits, including through WHO's clinical registry platform, and to adapt and operationalize WHO standards on infrastructure, personnel and material resources for emergency, critical and operative care services;

(10) to establish, as appropriate, regulation and certification mechanisms for all personnel and equipment required to deliver emergency, critical and operative care services to ensure professional competency and high quality;

(11) to provide dedicated pre- and in-service skill-based training in emergency, critical and operative care for all relevant health workers and inter-professional teams, including post-graduate training for doctors and nurses, training first-contact providers in WHO Basic Emergency Care, training community first aid responders, and integrating dedicated training in emergency, critical and operative care into undergraduate nursing and medical curricula, and establishing certification pathways for prehospital providers, as appropriate to national context, taking advantage of the existing WHO training platforms, such as the WHO Academy, as a key resource;

(12) to implement mechanisms for standardized and disaggregated data collection to characterize and report the relevant disease burden and identify high-yield mechanisms for improving the coordination, safety and quality of delivery of emergency, critical and operative care and to demonstrate the contribution of such integrated care to national targets, sustainable development goals and programmatic goals;

¹ <https://www.who.int/emergencies/operations/international-health-regulations-monitoring-evaluation-framework/national-action-plan-for-health-security> (accessed 25 January 2023).

(OP)3. REQUESTS the Director-General:

- (1) to enhance WHO's capacity at all levels, with emphasis on country offices, to provide necessary coordination, technical guidance and support for the efforts of Member States and other relevant actors to strengthen delivery of emergency, critical and operative care, including health emergency preparedness, readiness, response and recovery, across the spectrum of health services;
- (2) to promote strengthening of routine emergency, critical and operative care services for a more responsive and resilient health system, and ensure that strengthening of emergency, critical and operative care services is included in strategies for mitigating the impact of health emergencies;
- (3) to foster collaboration across relevant sectors, partnerships and action plans, and to facilitate collaboration among Member States, to support the effective dissemination and implementation of best practices and WHO resources for delivery of emergency, critical and operative care;
- (4) to create guidance for and support the development of integrated national and/or regional action plans for emergency, critical and operative care and to extend and strengthen community-based emergency, critical and operative care services;
- (5) to renew relevant efforts outlined in resolution WHA68.15 (2015) and resolution WHA72.16 (2019) to provide guidance and support to Member States for review of regulations and legislation for quality- and safety-improvement programmes with continued support for WHO's clinical registry and audit platform, and for other aspects of strengthening the provision of emergency, critical and operative care services;
- (6) to support Member States to expand policy-making, technological, administrative and clinical capacity in the area of emergency, critical and operative care, by the provision of policy options and technical guidance, supported by educational strategies and materials for health providers and planners;
- (7) to develop guidance for the consideration of Member States on comprehensive monitoring of emergency, critical and operative care services, taking into account their timeliness, quality and extensive scope, to provide data and information to be used in the development of emergency, critical and operative care services, basic and continuous training and regulation of the emergency, critical and operative care workforce;
- (8) to support Member States to identify high-priority emergency, critical and operative care services and to evaluate the planning and cost implications of integrating of these services into universal health coverage, such as through the WHO Service package delivery and implementation (SPDI) tool;
- (9) to strengthen the evidence base for emergency, critical and operative care interventions by encouraging research and supporting Member States to execute research on emergency, critical and operative care delivery, including by providing tools, protocols, indicators and other needed standards to support the collection, analysis and reporting of data, including on cost-effectiveness;
- (10) to support the integration of health facility planning, including for hospitals, with emergency, critical and operative care services, executed in line with communities' priorities and health needs, and with regard to supporting the central role of primary care, in accordance with the principles of a primary health care approach;
- (11) to support Member States to identify innovative and sustainable financing mechanisms to ensure access to essential emergency, critical and operative care services, and to facilitate awareness and international and domestic resource

mobilization, in line with the Addis Ababa Action Agenda of the Third International Conference on Financing for Development¹ by providing advocacy resources; (12) to report on progress in the implementation of this resolution to the Health Assembly in 2025, 2027 and 2029.

The financial and administrative implications of the draft decision for the Secretariat were:

Decision:	Integrated emergency, critical and operative care for universal health coverage and protection from health emergencies
A. Link to the approved revised Programme budget 2022–2023	
1. Output(s) in the approved revised Programme budget 2022–2023 under which this draft decision would be implemented if adopted:	<p>1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages.</p> <p>2.3.2. Acute health emergencies rapidly responded to, leveraging relevant national and international capacities.</p> <p>2.3.3. Essential health services and systems maintained and strengthened in fragile, conflict-affected and vulnerable settings.</p>
2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved revised Programme budget 2022–2023:	Not applicable.
3. Any additional Secretariat work during the biennium 2022–2023 that cannot be accommodated within the approved revised Programme budget 2022–2023 ceiling:	Not applicable.
4. Estimated time frame (in years or months) to implement the decision:	Within 6.5 years.
B. Resource implications for the Secretariat for implementation of the decision	
1. Total budgeted resource levels required to implement the decision, in US\$ millions:	US\$ 55.50 million.
2.a. Estimated resource levels required that can be accommodated within the approved revised Programme budget 2022–2023 ceiling, in US\$ millions:	US\$ 3.50 million.
2.b. Estimated resource levels required in addition to those already budgeted for in the approved revised Programme budget 2022–2023, in US\$ millions:	Not applicable.
3. Estimated resource levels required to be budgeted for in the proposed programme budget for 2024–2025, in US\$ millions:	US\$ 12.00 million.

¹ United Nations General Assembly resolution 70/1 (2015).

4. Estimated resource levels required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:	US\$ 40.00 million.
5. Level of resources already available to fund the implementation of the decision in the current biennium, in US\$ millions	
– Resources available to fund the decision in the current biennium:	US\$ 2.00 million.
– Remaining financing gap in the current biennium:	US\$ 1.50 million.
– Estimated resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:	Not applicable.

Table. Breakdown of estimated resource requirements (in US\$ millions)^a

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2022–2023 resources already planned	Staff	0.26	0.23	0.22	0.24	0.20	0.22	0.54	1.90
	Activities	0.10	0.10	0.10	0.10	0.10	0.10	1.00	1.60
	Total	0.36	0.33	0.32	0.34	0.30	0.32	1.54	3.50
B.2.b. 2022–2023 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2024–2025 resources to be planned	Staff	0.50	0.45	0.45	0.75	0.40	0.45	1.00	4.00
	Activities	1.20	1.20	1.20	1.20	1.20	1.20	0.80	8.00
	Total	1.70	1.65	1.65	1.95	1.60	1.65	1.80	12.00
B.4. Future bienniums resources to be planned	Staff	2.30	2.20	2.00	2.30	1.80	2.00	3.80	16.40
	Activities	3.60	3.50	3.50	3.50	3.50	3.50	2.50	23.60
	Total	5.90	5.70	5.50	5.80	5.30	5.50	6.30	40.00

^a The row and column totals may not always add up, owing to rounding.

The Board was further invited to consider a draft decision on increasing access to medical oxygen proposed by Australia, Bangladesh, the Central African Republic, the Member States of the European Union, Kenya, Türkiye and Uganda, which read:

The Executive Board, having considered the report on reorienting health systems to primary health care as a resilient foundation for universal health coverage,¹

Decided to recommend to the Seventy-sixth World Health Assembly the adoption of the following resolution:

¹ Document EB152/5.

The Seventy-sixth World Health Assembly,

(PP1) Recognizing the inclusion of medical oxygen as a life-saving essential medicine with no substitute on the 22nd World Health Organization Model List of Essential Medicines¹ and the 8th World Health Organization Model List of Essential Medicines for Children,² where it is an indication for the management of hypoxaemia, including for vulnerable groups, and anesthesia that is essential for surgery and trauma;

(PP2) Reaffirming the critical role of medical oxygen in the achievement of the Sustainable Development Goals (SDGs) for health, including reducing maternal mortality (SDG target 3.1), newborn and child mortality (SDG target 3.2) and premature mortality from chronic conditions (SDG target 3.4), and that medical oxygen has a role in the acute treatment of some AIDS-, tuberculosis- and malaria-related conditions (SDG target 3.3) and road traffic injuries (SDG target 3.6), and accelerating progress towards universal health coverage (SDG target 3.8);

(PP3) Noting that the wide application of medical oxygen is essential for the treatment of hypoxaemia across many communicable and noncommunicable diseases and medical conditions, across the life course, to which older persons in particular are vulnerable, including but not limited to coronavirus disease (COVID-19), pneumonia, tuberculosis and chronic obstructive pulmonary disease, and situations requiring surgery, emergency and critical care, and therefore necessary for the achievement of the goals and targets in the Global action plan for the prevention and control of NCDs 2013–2020,³ the End TB Strategy,⁴ the WHO package of essential noncommunicable (PEN) disease interventions for primary health care⁵ and WHO Guidelines for Safe Surgery 2009;⁶

(PP4) Underscoring that medical oxygen access is particularly critical for pregnant women during and after delivery, newborns in respiratory distress and children with pneumonia, and therefore necessary for the achievement of the goals and targets in the Global Strategy for Women's, Children's and Adolescent's health,⁷ the Every Newborn Action Plan⁸ and The integrated Global Action Plan for Pneumonia and Diarrhoea;⁹

¹ World Health Organization Model List of Essential Medicines – 22nd List, 2021. Geneva: World Health Organization; 2021. (<https://www.who.int/publications/i/item/WHO-MHP-HPS-EML-2021.02>, accessed 31 August 2022).

² World Health Organization Model List of Essential Medicines for Children – 8th List, 2021. Geneva: World Health Organization; 2021. (<https://www.who.int/publications/i/item/WHO-MHP-HPS-EML-2021.03>, accessed 31 August 2022).

³ Global action plan for the prevention and control of NCDs 2013–2020. Geneva: World Health Organization; 2013. (<https://www.who.int/publications/i/item/9789241506236>, accessed 31 August 2022).

⁴ The End TB Strategy. Geneva: World Health Organization; 2015. (<https://www.who.int/publications/i/item/WHO-HTM-TB-2015.19>, accessed 31 August 2022).

⁵ WHO package of essential noncommunicable (PEN) disease interventions for primary health care. Geneva: World Health Organization; 2020. ([https://www.who.int/publications/i/item/who-package-of-essential-noncommunicable-\(pen\)-disease-interventions-for-primary-health-care](https://www.who.int/publications/i/item/who-package-of-essential-noncommunicable-(pen)-disease-interventions-for-primary-health-care), accessed 31 August 2022).

⁶ WHO Guidelines for Safe Surgery 2009. Geneva: World Health Organization; 2009. (<https://www.who.int/publications/i/item/9789241598552>, accessed 31 August 2022).

⁷ Global Strategy for Women's, Children's and Adolescents' Health. Geneva: World Health Organization; 2015. (https://platform.who.int/docs/default-source/mca-documents/rmncah/global-strategy/ewec-globalstrategyreport-200915.pdf?Status=Master&sfvrsn=b42b6d22_4, accessed 31 August 2022).

⁸ The Every Newborn Action Plan. Geneva: World Health Organization; 2014. (<https://www.who.int/initiatives/every-newborn-action-plan>, accessed 31 August 2022).

⁹ The integrated Global Action Plan for Pneumonia and Diarrhoea. Geneva: World Health Organization; 2013. ([https://www.who.int/publications/i/item/the-integrated-global-action-plan-for-prevention-and-control-of-pneumonia-and-diarrhoea-\(gappd\)](https://www.who.int/publications/i/item/the-integrated-global-action-plan-for-prevention-and-control-of-pneumonia-and-diarrhoea-(gappd)), accessed 31 August 2022).

(PP5) Concerned that complications due to preterm birth are the leading cause of global neonatal mortality and recalling that WHO recommends support for respiratory distress syndrome and the importance of safe medical oxygen use to prevent injury from toxic levels of oxygen in the blood resulting in retinopathy of prematurity (one of the leading causes of child blindness) and chronic lung disease;

(PP6) Concerned that in developing countries not all health facilities have uninterrupted access to medical oxygen, and that lack of access is contributing to preventable deaths – a problem that has been exacerbated by the COVID-19 pandemic when the need for medical oxygen has exceeded the capacities of many health systems;

(PP7) Recalling the publication of WHO medical oxygen treatment guidelines, good practices, technical specifications, forecasting tools, training videos, consultations, safety guidelines¹ and the 2022 revisions to the monograph on Medicinal Oxygen that was adopted at the 56th meeting of the WHO Expert Committee on Specifications for Pharmaceutical Preparations for publication in the 11th Edition of The International Pharmacopoeia,² which collectively aim to improve access to medical oxygen through the appropriate selection, procurement, instalment, and operation and maintenance of medical oxygen systems and related infrastructure by Member States;

(PP8) Acknowledging the inclusion of pulse oximeters and other medical oxygen-related devices as priority medical devices listed in Core Medical Equipment,³ the Interagency list of medical devices for essential interventions for reproductive, maternal, newborn and child health,⁴ the WHO list of priority medical devices for cancer management,⁵ the Priority medical devices list for the COVID-19 response and associated technical specifications,⁶ WHO-UNICEF Technical specifications and guidance for oxygen therapy devices⁷ and the List of Priority Medical Devices for management of cardiovascular diseases and diabetes,⁸ and that medical oxygen devices are also regularly highlighted in the WHO compendium of innovative health technologies for low-resource settings;⁹

¹ Oxygen [website]. Geneva: World Health Organization; (n.d.). (https://www.who.int/health-topics/oxygen#tab=tab_1, accessed 31 August 2022).

² Medicinal Oxygen. Geneva: World Health Organization; 2022. (https://cdn.who.int/media/docs/default-source/essential-medicines/norms-and-standards/qas20-867-medicinal-oxygen.pdf?sfvrsn=ab60e2fe_5, accessed 31 August 2022).

³ Core Medical Equipment. Geneva: World Health Organization; 2011. (<https://www.who.int/publications/i/item/WHO-HSS-EHT-DIM-11.03>, accessed 31 August 2022).

⁴ Interagency list of medical devices for essential interventions for reproductive, maternal, newborn and child health. Geneva: World Health Organization; 2016. (<https://www.who.int/publications-detail-redirect/9789241565028>, accessed 31 August 2022).

⁵ WHO list of priority medical devices for cancer management. Geneva: World Health Organization; 2017. (<https://www.who.int/publications/i/item/9789241565462>, accessed 31 August 2022).

⁶ Priority medical devices list for the COVID-19 response and associated technical specifications. Geneva: World Health Organization; 2020. (<https://www.who.int/publications/i/item/WHO-2019-nCoV-MedDev-TS-O2T.V2>, accessed 31 August 2022).

⁷ WHO-UNICEF Technical specifications and guidance for oxygen therapy devices. Geneva: World Health Organization; 2019. (<https://www.who.int/publications/i/item/9789241516914>, accessed 26 January 2023).

⁸ WHO launches List of Priority Medical Devices for management of cardiovascular diseases and diabetes. Geneva: World Health Organization; 2021. (<https://www.who.int/news/item/30-06-2021-who-launches-list-of-priority-medical-devices-for-management-of-cardiovascular-diseases-and-diabetes>, accessed 31 August 2022).

⁹ WHO compendium of innovative health technologies for low-resource settings. Geneva: World Health Organization; 2022. (<https://www.who.int/publications/i/item/9789240049505>, accessed 31 August 2022).

(PP9) Acknowledging the role of the ACT-A Oxygen Emergency Taskforce¹ in helping developing countries finance urgently needed medical oxygen supplies to meet the surging demand during the COVID-19 pandemic and recognizing that large gaps in access to medical oxygen remain globally unaddressed, especially in developing countries;

(PP10) Highlighting the opportunity to consider medical oxygen in pandemic preparedness and response efforts, including through domestic and international funding; and

(PP11) Recognizing resolution WHA72.8 (2019) on improving the transparency of markets for medicines, vaccines, and other health products, in order to enhance availability and affordability of medical oxygen, particularly in developing countries,

(OP)1. URGES Member States,² taking into account their national contexts:

- (1) to include medical oxygen and associated medical devices on national lists of essential medicines and medical devices for adults and children, including to address treat hypoxaemia and anesthesia, for relevant communicable and noncommunicable conditions and injuries for all relevant patients, including for maternal, newborn, infants and children;
- (2) to develop, as appropriate, costed national plans to increase access to quality assured, affordable medical oxygen systems and personnel to meet the identified needs of all patients in the context of national achievement of the health SDG targets and universal health coverage;
- (3) to develop national, regional and local health regulations, policies and plans that are informed by but not limited to WHO guidelines and technical specifications relating to medical oxygen and associated medical devices;
- (4) to assess the scale of medical oxygen access gaps in their health systems, including at subnational- and local-level health facilities, in order to provide patients with the required amounts of medical oxygen and related diagnostic tools (including pulse oximeters and patient monitors), and medical devices that deliver oxygen therapy (including invasive and non-invasive ventilators, and continuous positive airway pressure), and availability of qualified staff;
- (5) to update their national pharmacopoeia as appropriate, informed by provisions on medical oxygen in The International Pharmacopoeia;
- (6) to prevent toxic levels of medical oxygen and the provision of safe medical oxygen among preterm newborns, by using blenders, pulse oximeters and equipment that meet global standards for technical specifications;
- (7) to consider conducting regular assessments to provide for rational use of oxygen, in order to prevent under-utilization, overuse and/or inappropriate use of medical oxygen;
- (8) to consider including, as appropriate, access to medical oxygen, related diagnostics and therapies, and all medical oxygen systems and personnel in national strategies for pandemic preparedness and response and other health emergencies, including for infectious disease outbreaks;

¹ Chaired by Unitaaid, the ACT-A Oxygen Emergency Taskforce includes WHO (and the broader biomedical consortium WHO coordinates), Unicef, The Global Fund, the World Bank, UNOPS, USAID, the Bill & Melinda Gates Foundation, the Clinton Health Access Initiative, Program for Appropriate Technology in Health, Access to Medicine Foundation, Save the Children, Every Breath Counts (coalition). COVID-19 oxygen emergency impacting more than half a million people in low- and middle-income countries every day, as demand surges. Geneva: World Health Organization; 2021. (<https://www.who.int/news/item/25-02-2021-covid-19-oxygen-emergency-impacting-more-than-half-a-million-people-in-low--and-middle-income-countries-every-day-as-demand-surges>, accessed 31 August 2022).

² And, where applicable, regional economic integration organizations.

- (9) to provide for adequate numbers of clinical staff to be appropriately trained to provide clinical assessments for hypoxaemia and to administer medical oxygen therapy, including as part of comprehensive emergency, critical and operative care services across all clinical settings;
- (10) to provide for availability of qualified staff including engineers and other staff required to establish demand, select, set up, operate and maintain the equipment and all the infrastructure related to medical oxygen production, storage and uninterrupted distribution to patients;
- (11) to monitor access to safe, affordable, quality assured medical oxygen and related services throughout the health system, as part of national efforts to achieve universal health coverage;
- (12) to raise public awareness, as appropriate, about the life-saving role of medical oxygen as a treatment for many conditions, including the critical role of pulse oximetry as a routine screening tool, to increase public understanding of hypoxaemia and its consequences, and to build confidence in health system capacities to meet medical oxygen needs;
- (13) to set up, as appropriate, national and subnational medical oxygen systems in order to secure the uninterrupted provision of medical oxygen to health care facilities at all levels comprising rural and urban set-ups;
- (14) to consider the stepwise integration of medical oxygen and other medical gas systems into the construction of health care infrastructure to improve accessibility and reduce the risk of bottled medical oxygen shortages;
- (15) to consider increasing domestic financing as well as international support for medical oxygen and provide transparent procurement and tendering processes, as appropriate, to ensure resilient supply chains for sustainable local manufacturing and procurement of medical oxygen and related diagnostic tools and therapies;
- (16) to invest, as appropriate, in medical oxygen innovations with the potential to increase access to quality assured, affordable and reliable supplies of medical oxygen and related diagnostic tools and therapies, including those suitable for low-resource settings;
- (17) to promote good manufacturing practice through strengthening of quality control in the production chain, filling and distribution of medical oxygen;
- (18) to promote research, including translational research, to improve access, quality and safety of medical oxygen in health care settings;
- (19) to promote mutual support, assistance and cooperation to increase access to medical oxygen; and
- (20) to integrate medical oxygen data into routine health information systems;

(OP)2. REQUESTS the Director-General:

- (1) to continue to highlight medical oxygen as an essential medicine and to highlight the related priority medical devices and infrastructure that must be available to all patients who need them as part of quality health systems contributing to universal health coverage;
- (2) to support Member States to improve access to medical oxygen by developing guidelines, technical specifications, forecasting tools, training materials and other resources, and provide technical support especially designed to meet the needs of health systems in developing countries;
- (3) to promote convergence and harmonization of regulations governing the provision of medical oxygen and access to safe, effective and quality assured medical oxygen sources and devices that meet standards set by WHO and competent authorities;

- (4) to support Member States' efforts to provide adequate, predictable and sustainable financing for affordable medical oxygen and for the trained workforce required to safely install, operate and maintain the medical oxygen systems;
- (5) to include medical oxygen supply in WHO-related pandemic, preparedness and response efforts;
- (6) to review medical oxygen innovations and promote sharing of the innovations among Member States on voluntary and mutually agreed terms to increase access to quality, affordable and reliable supplies of medical oxygen and related diagnostic tools and therapies in low-resource settings;
- (7) to establish a research agenda as needed regarding the use of medical oxygen;
- (8) to collect and analyse data and share best practices in closing gaps to medical oxygen access in health systems;
- (9) to regularly consult with relevant non-State actors on all aspects of access to medical oxygen and to enable partnerships between non-State actors and Member States in the design and delivery of medical oxygen solutions;
- (10) to promote mutual support, assistance and cooperation among all stakeholders to increase access to medical oxygen; and
- (11) to report on progress in the implementation of this resolution to the Health Assembly in 2026, 2028 and 2030.

The financial and administrative implications of the draft decision for the Secretariat were:

Decision:	Increasing access to medical oxygen
A. Link to the approved revised Programme budget 2022–2023	
1. Output(s) in the approved revised Programme budget 2022–2023 under which this draft decision would be implemented if adopted:	<p>1.3.1. Provision of authoritative guidance and standards on quality, safety and efficacy of health products, essential medicines and diagnostics lists.</p> <p>1.3.2. Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems.</p> <p>1.3.3. Country and regional regulatory capacity strengthened, and supply of quality-assured and safe health products improved, including through prequalification services.</p>
2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved revised Programme budget 2022–2023:	Not applicable.
3. Any additional Secretariat work during the biennium 2022–2023 that cannot be accommodated within the approved revised Programme budget 2022–2023 ceiling:	Zero.
4. Estimated time frame (in years or months) to implement the decision:	Seven years.
B. Resource implications for the Secretariat for implementation of the decision	
1. Total budgeted resource levels required to implement the decision, in US\$ millions:	US\$ 17.10 million.

2.a. Estimated resource levels required that can be accommodated within the approved revised Programme budget 2022–2023 ceiling, in US\$ millions:
US\$ 1.44 million.
2.b. Estimated resource levels required in addition to those already budgeted for in the approved revised Programme budget 2022–2023, in US\$ millions:
Not applicable.
3. Estimated resource levels required to be budgeted for in the proposed programme budget for 2024–2025, in US\$ millions:
US\$ 8.29 million.
4. Estimated resource levels required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:
US\$ 7.37 million.
5. Level of resources already available to fund the implementation of the decision in the current biennium, in US\$ millions
– Resources available to fund the decision in the current biennium:
US\$ 1.44 million.
– Remaining financing gap in the current biennium:
Zero.
– Estimated resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:
Zero.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2022–2023 resources already planned	Staff	0.05	0.07	0.05	0.05	0.05	0.05	0.33	0.65
	Activities	0.06	0.05	0.05	0.04	0.05	0.04	0.50	0.79
	Total	0.11	0.12	0.10	0.09	0.10	0.09	0.83	1.44
B.2.b. 2022–2023 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2024–2025 resources to be planned	Staff	0.60	0.50	0.50	0.45	0.43	0.50	1.26	4.24
	Activities	1.00	0.65	0.60	0.30	0.50	0.50	0.50	4.05
	Total	1.60	1.15	1.10	0.75	0.93	1.00	1.76	8.29
B.4. Future bienniums resources to be planned	Staff	0.60	0.50	0.50	0.44	0.43	0.44	1.26	4.17
	Activities	0.70	0.55	0.45	0.25	0.45	0.40	0.40	3.20
	Total	1.30	1.05	0.95	0.69	0.88	0.84	1.66	7.37

The CHAIR also invited the Board to consider a draft decision on preparation for the high-level meeting of the United Nations General Assembly on universal health coverage proposed by Australia, Bangladesh, Brazil, Canada, China, Egypt, the Member States of the European Union, Israel, Japan, Malaysia, Mexico, the Philippines, Switzerland, Thailand, Timor-Leste, the United Kingdom of Great Britain and Northern Ireland, the United States of America and Vanuatu, which read:

The Executive Board, having considered the report on re-orienting health systems to primary health care as a resilient foundation for universal health coverage,¹

Decided to recommend to the Seventy-sixth World Health Assembly the adoption of the following resolution:

The Seventy-sixth World Health Assembly,

(PP1) Reaffirming the right of every human being, without distinction of any kind, to the enjoyment of the highest attainable standard of physical and mental health;

(PP2) Recalling United Nations General Assembly resolution 70/1 (2015) on transforming our world: the 2030 Agenda for Sustainable Development, resolutions WHA72.4 (2019) on preparation for the high-level meeting of the United Nations General Assembly on universal health coverage and WHA72.2 (2019) on primary health care, United Nations General Assembly resolution 74/2 (2019) on the political declaration of the high-level meeting on universal health coverage, and United Nations General Assembly resolution 75/315 (2021) on scope, modalities, format and organization of the high-level meeting on universal health coverage;

(PP3) Recognizing that the 2030 Agenda for Sustainable Development acknowledges the need to achieve universal health coverage and access to quality health care, and further recognizing that vital contribution of universal health coverage is fundamental for achieving the Sustainable Development Goals (SDGs) related not only to health and well-being, but also to other socio-economic development and recognizing that

¹ Document EB152/5.

achievement of the SDGs is critical for the attainment of healthy lives and well-being for all, with a focus on health outcomes throughout the life course;

(PP4) Recognizing that health system resilience and universal health coverage are central for effective and sustainable preparedness, prevention and response to pandemics and other public health emergencies;

(PP5) Recognizing the 2030 Agenda for Sustainable Development acknowledges the fundamental role of primary health care in achieving universal health coverage and other health-related Sustainable Development Goals and targets, as envisioned in the Alma-Ata Declaration and the Declaration of Astana from the Global Conference on Primary Health Care, and that primary health care and health services should be high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, and provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed;

(PP6) Recognizing the need for health systems that are strong, resilient, functional, well governed, responsive, accountable, integrated, community-based, person-centred with enhanced patient safety, and capable of quality service delivery supported by a sufficiently funded and accessible competent health workforce, adequate health infrastructure, enabling legislative and regulatory frameworks that support equitable access to responsive and quality health services;

(PP7) Recognizing that communities, local administrations and organizations are central to achieving universal health coverage and support efforts to provide community-based health services, improve access to quality health services and care for hard-to-reach communities, including in humanitarian contexts;

(PP8) Expressing concern at the global shortfall of 15 million in the health workforce in 2020, primarily in low- and middle-income countries, and recognize the need to attract, educate, build and retain a skilled health workforce, including doctors, nurses, midwives and community health workers, who are a fundamental element of strong and resilient health systems; and recognizing that 70% of health and care workers are women and that gender inequalities undermine health system performance and global health security;

(PP9) Expressing concern over working conditions and management of the health workforce, as well as the challenge of retaining skilled health workers, and recognizing the need for governments to invest in health workforce education and improved working conditions for the health workforce, and to ensure the safety of health workers, including during pandemics;

(PP10) Recognizing the importance of preventing and responding to sexual exploitation, abuse and harassment of and by the health workforce;

(PP11) Noting with concern the threat to human health, safety and well-being caused by the coronavirus disease (COVID-19) pandemic, which has spread all over the globe and exposed the vulnerability of current global health architecture, as well as the unprecedented and multifaceted effects of the pandemic, including the severe disruption to societies, education, health systems in maintaining essential health services, economies, international trade and travel and the devastating impact on the livelihoods of people;

(PP12) Recognizing the consequence of the adverse impact of climate change on health and health systems, as well as other environmental determinants of health and underscoring the need to mitigate these impacts through adaptation and mitigation efforts, and underlining that resilient and people-centred health systems are necessary to protect the health of all people;

(PP13) Expressing concern that the 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;

(PP14) Noting the improvement of SDG indicator 3.8.1 on coverage of essential health services by 2019 while expressing concern for the increased prevalence of catastrophic health spending (SDG indicator 3.8.2);

(PP15) Expressing concern that the unmet healthcare needs, in particular among poor households that cannot afford the cost of health services, can result in increased morbidity and mortality due to lack of or delayed accesses,

(OP)1. URGES Member States:¹

(1) to engage in the preparation of the high-level meeting of the United Nations General Assembly on universal health coverage, including the development of a concise and action-oriented, consensus-based political declaration, and to participate in the high-level meeting of the United Nations General Assembly in 2023 on universal health coverage at the highest level, preferably at the level of Heads of State and Government;

(2) to coordinate across the three high-level meetings of the United Nations General Assembly on universal health coverage, on tuberculosis and on pandemic prevention, preparedness and response to promote a coherent, integrated and action-oriented global health agenda and to maximize synergies of those meetings;

(3) to accelerate the achievement of universal health coverage as committed in resolution WHA72.4 (2019) and United Nations General Assembly resolution 74/2 (2019), through increased and sustained political leadership, public accountability, inclusiveness and social participation by all relevant stakeholders;

(4) to increase COVID-19 vaccine coverage according to WHO and nationally determined coverage targets by reaching the highest coverage among the priority-use groups and health workforce including consideration of integration into immunization programmes and primary health care, in order to conclude the acute phase of pandemic, and to strengthen health systems resilience, in particular health delivery systems and health workforce, including systems to prevent and respond to sexual exploitation, abuse and harassment of and by the health workforce, as a platform for the full and effective implementation of universal health coverage by 2030;

(5) to prioritize fiscal space for health through political leadership, improve health systems efficiency, address the environmental, social and economic determinants of health, reduce waste in health systems, identify new sources of revenue, mobilize domestic resources as the main source of financing for universal health coverage, as well as additional financing sources in line with SDG 17 improve public financial management, accountability and transparency, and prioritize coverage of the poor and people in vulnerable situations;

(6) to provide a comprehensive evidence-based benefit package to expand access to quality health services on the path towards progressive realization of universal health coverage informed by cost-effectiveness evidence and reduce reliance on out-of-pocket payment to minimize catastrophic health spending in order to achieve the goal of health equity;

(7) to ensure, 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, and

¹ And, where applicable, regional economic integration organizations.

ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences;

(8) to integrate, where relevant, essential public health functions into primary health care including surveillance and outbreak control and supporting a One Health approach, sustain capacity for universal health coverage, scale up telemedicine to increase access to affordable essential health services and maintain all essential health services during emergencies, including through international cooperation;

(9) to strengthen regular monitoring and evaluation for performance improvement of universal health coverage, and to provide information to support global, regional and national monitoring of progress on universal health coverage and inform preparations for the high-level meeting of the United Nations General Assembly on universal health coverage as well as inform ongoing efforts to achieve the SDGs;

(OP)2. REQUESTS the Director-General:

(1) to provide support to Member States in the preparations for the high-level meeting of the United Nations General Assembly on universal health coverage, and coordinate across the high-level meetings of the United Nations General Assembly on universal health coverage, tuberculosis and pandemic prevention, preparedness and response, in order to ensure synergies among the three meetings and promote coherent, integrated and action-oriented global health agendas;

(2) to produce a report on universal health coverage as a technical input and hold Member States information sessions to facilitate informed discussions in advance of the negotiations on the political declaration and during the high-level meeting of the United Nations General Assembly on universal health coverage;

(3) to review the importance and feasibility of using unmet need for health care services as an additional indicator for monitoring universal health coverage, through regional consultations with Member States, as part of the ongoing WHO review process of health-related SDG indicators;

(4) to provide technical support and policy advice to Member States, in collaboration with the broader United Nations system and other relevant stakeholders, on sustainably strengthening their capacity to generate and use evidence to inform the design and implementation of universal health coverage, strengthening primary health care, promoting access to quality-assured medical products, essential medicines, vaccines, diagnostics and devices, and addressing challenges in health workforce, including to support Member States to prevent and respond to sexual exploitation, abuse and harassment of and by the health workforce, as well as addressing challenges in health information systems and health financing;

(5) to facilitate and support the learning from and sharing of universal health coverage experiences, challenges and best practices across WHO Member States, including in humanitarian and development contexts, including through international cooperation including North–South, South–South and triangular cooperation and relevant WHO initiatives;

(6) to support the implementation of the Global Action Plan for Healthy Lives and Well-being for All in order to accelerate progress towards health-related SDG targets, through collaboration across the relevant United Nations and non-United Nations health-related agencies, with coordinated approaches and aligned support for Member State-led national plans and strategies;

(7) to continue submitting biennial report on progress made in implementing this resolution to the Health Assembly, as requested by resolution WHA72.4 (2021).

The financial and administrative implications of the draft decision for the Secretariat were:

Decision:	Preparation for the high-level meeting of the United Nations General Assembly on universal health coverage
A. Link to the approved revised Programme budget 2022–2023	
1. Output(s) in the approved revised Programme budget 2022–2023 under which this draft decision would be implemented if adopted:	<p>1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages.</p> <p>1.1.3. Countries enabled to strengthen their health systems to address population-specific health needs and barriers to equity across the life course.</p> <p>1.1.5. Countries enabled to strengthen their health and care workforce.</p> <p>1.2.1. Countries enabled to develop and implement equitable health financing strategies and reforms to sustain progress towards universal health coverage.</p> <p>3.1.1. Countries enabled to address social determinants of health across the life course.</p> <p>3.3.1. Countries enabled to address environmental determinants, including climate change.</p>
2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved revised Programme budget 2022–2023:	Not applicable.
3. Any additional Secretariat work during the biennium 2022–2023 that cannot be accommodated within the approved revised Programme budget 2022–2023 ceiling:	Not applicable.
4. Estimated time frame (in years or months) to implement the decision:	Eight years (until 2030, aligned with the Sustainable Development Goals).
B. Resource implications for the Secretariat for implementation of the decision	
1. Total budgeted resource levels required to implement the decision, in US\$ millions:	US\$ 2105.64 million.
2.a. Estimated resource levels required that can be accommodated within the approved revised Programme budget 2022–2023 ceiling, in US\$ millions:	US\$ 138.12 million.
2.b. Estimated resource levels required in addition to those already budgeted for in the approved revised Programme budget 2022–2023, in US\$ millions:	Not applicable.
3. Estimated resource levels required to be budgeted for in the proposed programme budget for 2024–2025, in US\$ millions:	US\$ 425.01 million.
4. Estimated resource levels required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:	US\$ 1542.51 million.
5. Level of resources already available to fund the implementation of the decision in the current biennium, in US\$ millions	

- **Resources available to fund the decision in the current biennium:**
US\$ 20.00 million.
- **Remaining financing gap in the current biennium:**
US\$ 118.12 million.
- **Estimated resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
Not applicable.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2022–2023 resources already planned	Staff	17.60	4.36	8.56	5.16	6.40	5.96	7.21	55.25
	Activities	26.40	6.54	12.84	7.74	9.60	8.94	10.81	82.87
	Total	44.00	10.90	21.40	12.90	16.00	14.90	18.02	138.12
B.2.b. 2022–2023 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2024–2025 resources to be planned	Staff	56.65	24.63	21.49	8.19	17.44	19.43	22.17	170.00
	Activities	84.97	36.94	32.24	12.29	26.16	29.15	33.26	255.01
	Total	141.62	61.57	53.73	20.48	43.60	48.58	55.43	425.01
B.4. Future bienniums resources to be planned	Staff	194.36	65.84	57.45	55.83	111.10	51.95	80.48	617.01
	Activities	291.53	98.76	86.18	83.74	166.65	77.92	120.72	925.50
	Total	485.89	164.60	143.63	139.57	277.75	129.87	201.20	1542.51

The Board was further invited to consider a draft decision on strengthening diagnostics capacity proposed by Indonesia and the Member States of the African Region, which read:

The Executive Board, having considered the report on reorienting health systems to primary health care as a resilient foundation for universal health coverage,¹

Decided to recommend to the Seventy-sixth World Health Assembly the adoption of the following resolution:

The Seventy-sixth World Health Assembly,

(PP1) Recognizing the Alma-Ata Declaration of 1978, which identified primary health care as “essential health care based on practical, scientifically sound and socially acceptable methods and technology at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination”, and the Declaration of Astana (2018) on building sustainable primary health care in accordance with the 2030 Agenda for Sustainable Development’s call to achieve universal health coverage and health-related Sustainable Development Goals, and

¹ Document EB152/5.

that diagnostics are important to ensure quality, comprehensive, and integrated primary health care and health services for everyone and everywhere;

(PP2) Recognizing that diagnostic services are vital for the prevention, diagnosis, case management, monitoring and treatment of communicable, noncommunicable, neglected tropical and rare diseases, injuries and disabilities;

(PP3) Noting that the WHO Constitution upholds the enjoyment of the highest attainable standard of health as a fundamental right of every human being, without distinction of race, religion, political belief, economic or social condition and recognizing that the achievement of any State in the promotion and protection of health is of value to all, and governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures;

(PP4) Recognizing that access to diagnostics in many countries may be reduced for households living in remote and rural areas, hard to reach and pastoralist communities, low-income households, and people in vulnerable situations, as well as those at higher risk of disease, and that equitable access to diagnostics, in particular diagnostic imaging in developing countries, is particularly deficient and that targeted efforts are needed to lift these barriers;

(PP5) Recognizing that increasing access to diagnostics from current levels could reduce annual premature deaths, including for people living in developing countries;

Noting that equitable access to safe, effective and quality assured diagnostics requires a comprehensive health-systems approach that addresses all stages of the value chain;

(PP6) Recalling also the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) as amended, and recalling the 2001 Doha Declaration on the TRIPS Agreement and Public Health, which affirms that the TRIPS Agreement can and 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 recognizes that intellectual property protection is important for the development of new medicines and also recognizes the concerns about its effects on prices (ref: res on local production);

(PP7) Recalling resolution WHA67.20 (2014) on regulatory system strengthening for medical products, requesting the Director-General to prioritize support for “strengthening areas of regulation of products that are the least developed, such as regulation of medical devices, including diagnostics”;¹

(PP8) Recalling resolution WHA67.23 (2014) on health intervention and technology assessment in support of universal health coverage;²

(PP9) Noting regional resolutions and initiatives on: regulation, assessment, or management of medical devices including in vitro diagnostics and on strengthening public health laboratories;³

¹ Regulatory system strengthening for medical products, resolution WHA67.20
https://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_R20-en.pdf (accessed 17 October 2022).

² Health intervention and technology assessment in support of universal health coverage, resolution WHA67.23
https://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_R23-en.pdf (accessed 5 January 2022).

³ Strengthening Public Health Laboratories in the WHO African Region: A Critical Need For Disease Control.
<https://www.afro.who.int/sites/default/files/sessions/resolutions/AFR-RC58-6.pdf> (accessed 4 January 2023).

(PP10) Noting the publication of the First WHO Model List of Essential In Vitro Diagnostics¹ (2019); followed by the second edition² (2020), third edition³ (2021), the guidance on selection of in vitro diagnostics at country level;⁴ and the Guidance for procurement of in vitro diagnostics and related laboratory items and equipment;⁵

(PP11) Recalling resolution WHA60.29 (2007) on health technologies covering issues arising from the deployment and use of health technologies, and the need to establish priorities in the selection and management of health technologies, specifically medical devices;⁶

(PP12) Recognizing the development of the WHO Universal Health Coverage Compendium⁷ and the WHO Lists of Priority Medical Devices⁸ including those required for reproductive, maternal, newborn health,⁹ cancer management,¹⁰ COVID-19,¹¹ and cardiovascular diseases and diabetes,¹² and for covering the broad range of medical devices used for diagnostic purposes;

(PP13) Recognizing that some of the barriers to improving equitable access to medicines are similar to those for diagnostics and that the regulation, selection, process, training for proper use, maintenance and – where appropriate – infrastructure support, are different and some even more complex, nevertheless recognizing that synergies can be used wherever possible when addressing barriers to access to medicines and diagnostics;

(PP14) Recognizing the need to establish priorities in the management of diagnostics considering procurement,¹³ supply chain, maintenance, safe use and decommissioning, to

¹ First WHO Model List of Essential In Vitro Diagnostics. Geneva: World Health Organization; 2019 (WHO Technical Report Series, no. 1017). Licence: CC BY-NC-SA 3.0 IGO.
<https://apps.who.int/iris/bitstream/handle/10665/311567/9789241210263-eng.pdf?ua=1> (accessed 4 January 2023).

² The selection and use of essential in vitro diagnostics. (WHO technical report series, no. 1022). 2020. Available at <https://www.who.int/publications/i/item/9789241210317> (accessed 4 January 2023).

³ The selection and use of essential in vitro diagnostics. (WHO Technical Report Series, no 1031).
<https://www.who.int/publications/i/item/9789240019102> (accessed 31 January 2023).

⁴ Selection of essential in vitro diagnostics at country level. Geneva, WHO; 2021. Available at <https://www.who.int/publications/i/item/9789240030923> (accessed 31 October 2022).

⁵ Guidance for procurement of in vitro diagnostics and related laboratory items and equipment. Available at <https://www.who.int/publications/i/item/9789240030923> (accessed 4 January 2023).

⁶ Health technologies, resolution WHA60.29 https://apps.who.int/iris/bitstream/handle/10665/22609/A60_R29-en.pdf?sequence=1&isAllowed=y (accessed 4 January 2023).

⁷ UHC Compendium: Health interventions for universal health coverage. Geneva: World Health Organization; 2021.
<https://www.who.int/universal-health-coverage/compendium> (accessed 30 October 2022).

⁸ WHO Priority Medical Devices Lists <https://www.who.int/activities/prioritizing-medical-devices> (accessed 31 January 2023).

⁹ Interagency list of priority medical devices for Essential interventions for Reproductive, maternal, newborn and childcare (2016). https://apps.who.int/iris/bitstream/handle/10665/205490/9789241565028_eng.pdf (accessed 31 January 2023).

¹⁰ WHO list of priority medical devices for cancer management (2017).
<https://www.who.int/publications/i/item/9789241565462> (accessed 30 October 2022).

¹¹ Priority medical devices for the COVID-19 response and associated technical specifications (2020).
<https://www.who.int/publications/i/item/WHO-2019-nCoV-MedDev-TS-O2T.V2> (accessed 30 October 2022).

¹² WHO list of priority medical devices for management of cardiovascular diseases and diabetes (2021).
<https://www.who.int/publications/i/item/9789240027978> (accessed 30 October 2022).

¹³ Considering alternative procurement mechanisms, including pooled procurement, “bundled procurement” – including reagents, accessories–, private public partnerships (PPP), leasing, etc.

improve health outcomes through optimal use of the resources that are often capital intensive;

(PP15) Recognizing the critical role of rapid and accurate diagnostics to combat antimicrobial resistance by guiding the correct management of infections, and the appropriate use of new and existing antimicrobials through improved antimicrobial stewardship and surveillance;

(PP16) Recognizing the lack of equitable access to basic diagnostics in many parts of the world for priority pathogens, which have been identified by WHO as having the greatest outbreak potential;

(PP17) Recognizing that appropriate diagnostics are needed to inform prediction, prevention, detection, monitoring and control of outbreaks and pandemic diseases; and noting that diagnostics capacity at national and subnational levels is essential;

(PP18) Noting the emphasis of the Access to COVID-19 Tools Accelerator¹ (ACT-A) “to accelerate development, production, and equitable access to COVID-19 tests, treatments, and vaccines”;

(PP19) Noting the learnings derived from the Access to COVID-19 Tools Accelerator,² including its diagnostics pillar, regarding the strengths and weaknesses of ACT-A;

(PP20) Noting that during COVID-19 pandemic response, despite the sharing of the genome sequence of the novel coronavirus that paved the way for the rapid development of diagnostic tests, the lack of access for developing countries in particular, to diagnostic tests, created inequities in public health response;

(PP21) Noting that the benefit of diagnostics can be maximized by the suitable health system (including laboratories), which enables selection/regulation and use of them in a proper way, with the skilled and licensed workforce operating in safe and operational facilities with the appropriate infrastructure, and adequate financing;

(PP22) Recalling resolution WHA74.7 (2021) on strengthening WHO preparedness for and response to health emergencies, underscoring that timely, fair and equitable access to health products is a global priority and that the availability, accessibility, acceptability and affordability of health products are fundamental to tackling global public health emergencies;³

(PP23) Recognizing the increasing burden of noncommunicable diseases⁴ and WHO’s Global Action Plan for the Prevention and Control on Noncommunicable Diseases 2013–2030⁵ that includes addressing the lack of diagnostics for noncommunicable diseases through multistakeholder collaborations to develop new technologies that are affordable, safe, effective, and quality controlled, and improving laboratory and diagnostic capacity and human resources;⁶

(PP24) Recognizing the need to ensure the integrated and coordinated provision of high-quality, affordable, accessible, age and gender sensitive, and evidence-based

¹ *Ibid.*

² *Ibid.*

³ Strengthening WHO preparedness for and response to health emergencies, resolution WHA 74.7 (2021) Available at https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_R7-en.pdf (accessed 22 December 2022).

⁴ Including eye, ear and oral health.

⁵ Implementation roadmap 2023–2030 for the Global action plan for the prevention and control of NCDs 2013–2030 <https://www.who.int/teams/noncommunicable-diseases/governance/roadmap> (accessed 31 January 2023).

⁶ Global Action Plan for the Prevention and Control of NCDs 2013–2020. Geneva: World Health Organization; 2013. Available at <https://apps.who.int/iris/handle/10665/94384> (accessed 9 November 2022) (Reference to 80% of basic technologies).

diagnostic interventions, for all individuals without discrimination with a view to achieving universal health coverage;

(PP25) Noting the importance of point of care tests at the primary health care level as well as at the community level, including self-testing, to increase access, affordability and use of diagnostics;

(PP26) Noting the opportunities for improved diagnostics including, but not limited to, the research and development of simple, affordable tests for diseases currently lacking good quality tests, digitalization, teleradiology and clinical decision support and improved information management;¹ point-of-care testing, and genomic sequencing;

(PP27) Noting resolution WHA72.8 (2019) on improving the transparency of markets for medicines, vaccines, and other health products;²

Noting the challenges associated with the cost of diagnostic tests in developing countries that affect access;

(PP28) Recalling resolution WHA74.6 (2021) on strengthening local production of medicines and other health technologies to improve access, which “recalls resolutions WHA61.21 (2008), decision WHA71(9) (2018) and document A71/12 (2018), insofar as they address the role of technology transfer and local production of medicines and other health technologies in improving access;”³

(PP29) Noting that although high burden infectious diseases persist globally, considerable efforts over the last decade by Member States, WHO, donors and other stakeholders have expanded laboratory diagnostic services and access to in vitro diagnostics for several high burden infectious diseases,⁴

(OP)1. URGES Member States, taking into account their national context and circumstances:

- (1) to consider the establishment of a national diagnostics strategy, as part of their national health plan, that includes regulation, assessment and management of diagnostics and development of integrated networks to tackle all diseases and medical challenges, avoiding current silos often observed;
- (2) to consider health technology assessment system for systematic evaluation on effectiveness and cost-effectiveness of diagnostics to support decision-making, for the selection of diagnostics for interventions for universal health coverage;
- (3) to consider development of a national essential diagnostics list, adapting the WHO Model List of Essential In Vitro Diagnostics and the WHO lists of priority medical devices, to local context and plans to fund gaps in access to essential diagnostics, and to regularly update them;
- (4) to extend the scope of the package of essential diagnostic services, and to make essential diagnostics available, accessible and affordable at the primary healthcare level;

¹ WHO guideline: recommendations on digital interventions for health system strengthening. Executive summary. Geneva: World Health Organization; 2019. (WHO/RHR/19.8). Licence: CC BY-NC-SA 3.0 IGO.

² WHO and Health Action International. Measuring medicine prices, availability, affordability and price components, 2nd ed. 2008. https://apps.who.int/iris/bitstream/handle/10665/70013/WHO_PSM_PAR_2008.3_eng.pdf?sequence=1&isAllowed=y (accessed 25 November 2022).

³ Strengthening local production of medicines and other health technologies to improve access. resolution WHA74.6. Geneva: World Health Organization; 2021. Available at https://apps.who.int/gb/ebwha/pdf_files/WHA74-REC1/A74_REC1-en.pdf#page=27 (accessed 9 February 2022).

⁴ https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_R20-en.pdf ; https://cdn.who.int/media/docs/default-source/hq-hiv-hepatitis-and-stis-library/full-final-who-ghss-hiv-vh-sti_1-june2022.pdf?sfvrsn=7c074b36_13 (accessed 31 January 2023); Global technical strategy for malaria 2016-2030, 2021 update (who.int).

- (5) to invest in developing skilled workforce at all levels of the health system, with the training needed to support advances in diagnostics and the management of these technologies;
- (6) to commit to the safe use of diagnostic imaging procedures by applying standards based on the international basic safety standards, where appropriate, considering the protection of patients, staff and the public;¹
- (7) to commit resources to invest in research and product development and promote local production capacity for diagnostics,² particularly in developing countries;
- (8) to consider including provisions that facilitate access in funding agreements for research and development in diagnostics;
- (9) to take policy measures for equitable and timely access for all to diagnostics technologies and products, in particular for the benefit of developing countries, including joint development and transfer of diagnostics technologies, on voluntary and mutually agreed terms;
- (10) to take into account the rights and obligations in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement), including those affirmed by the Doha Declaration on the TRIPS Agreement and Public Health, in order to promote access to diagnostics and other health technologies for all;
- (11) to consider, as appropriate, legislative, administrative or policy measures to prevent anti-competitive practices that hinder access to diagnostics;
- (12) to leverage international and/or regional collaboration for harmonizing and promoting twinning practice and reliance mechanism for the regulation/manufacturing/supply of all types of diagnostics;
- (13) to establish routine data collection system for monitoring key data on the market shaping and effective use of diagnostics, and to use these data for evidence-based policy-making;
- (14) to invest in diagnostic services, including the selection and use of essential in vitro diagnostics;
- (15) to strengthen international collaboration and assistance, including during epidemics and pandemics, aligned with the International Health Regulations (2005);

(OP)2. REQUESTS the Director-General:

- (1) to collect data on affordability, availability and access to essential diagnostics;
- (2) to support, upon request of Member States and as appropriate, technical advice for procurement that will enable access to good quality affordable diagnostics for all Member States;³
- (3) to provide cross-references between the WHO Model List of Essential In Vitro Diagnostics and the diagnostic devices already included in the WHO Priority Medical Devices List, in order to facilitate the identification of relevant diagnostics

¹ International Basic Safety Standards: Report by the Secretariat. EB131/11. 2012. Available at https://apps.who.int/gb/ebwha/pdf_files/EB131/B131_11-en.pdf (accessed 4 January 2023).

² For the purpose of this resolution, “Diagnostics” as those medical devices used for: diagnostic, screening, monitoring, prediction, staging or surveillance of diseases or health condition including, both “in vitro” and “non in vitro”.

³ And, where applicable, regional economic integration organizations.

for comprehensive diagnostic services, in particular through the WHO electronic platforms: e-EDL¹ and MeDevis;²

(4) to update the WHO Model List of Essential in vitro diagnostics and WHO Lists of Priority Medical Devices, including innovative diagnostics, following review of latest evidence or health technology assessments;

(5) to support Member States, upon their request, to develop policies for health technology management of diagnostics including national maintenance systems and disposal;

(6) to continue to support Member States upon their request in promoting quality and sustainable local production of diagnostics, including, as appropriate, by facilitating research and development and technology transfer on voluntary and mutually agreed terms, and by coordinating with relevant international intergovernmental organizations in promoting local production in a strategic and collaborative approach;³

(7) to support Member States, upon their request, to strengthen national and regional regulatory systems for diagnostics;

(8) to support development and update of Member States' national diagnostics lists, considering the WHO lists, including cost-effectiveness and state-of-the-art diagnostics products and technologies;

(9) to categorize a subset of the WHO Essential Diagnostics List, tailored to emergency situations, including the Interagency Emergency Health Kits;⁴

(10) to publish publicly available information on diagnostic products and technologies⁵ from the WHO Model List of Essential In Vitro Diagnostics and the WHO lists of priority medical devices, through the WHO open platforms e-EDL and MeDevis;

(11) to develop or strengthen national, regional and global laboratory networks and diagnostics initiatives and to support Member States in developing and implementing quality management systems towards ensuring safe, affordable, accessible diagnostic services and quality assured diagnostics;

(12) to develop or update WHO definitions of diagnostics, through a group of experts and public consultations and to publish revised definitions before the 156th session of the Executive Board;

(13) to take a horizontal health programme approach for all diagnostics (both in vitro and non in vitro) across diseases and avoid siloed guidance, policy and funding streams;

(14) to support Member States in creating optimized, integrated diagnostic networks and services that best serve country programmes to tackle all diagnostic systems needs, removing the oftentimes siloed programmatic and diagnostic services;

¹ WHO Model List of Essential In Vitro Diagnostics, electronic platform. (<https://edl.who-healthtechnologies.org/>) (accessed 31 January 2023).

² WHO Priority Medical Devices information system (<https://medevis.who-healthtechnologies.org/>) (accessed 31 January 2023).

³ Strengthening local production of medicines and other health technologies to improve access, resolution WHA74.6 https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_R6-en.pdf (accessed 5 January 2022)

⁴ <https://www.who.int/emergencies/emergency-health-kits/interagency-emergency-health-kit-2017> (accessed 31 January 2023).

⁵ Decision WHA75(25) (2022), [https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75\(25\)-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75(25)-en.pdf) (accessed 31 January 2023).

- (15) to prioritize and rapidly review clinical evidence for new diagnostic interventions, services, or products for consideration in guidelines, across diseases with an effort to integrate recommendations in a disease-agnostic way, when possible;
- (16) to report on progress in the implementation of this resolution to the Health Assembly in 2025.

The financial and administrative implications of the draft decision for the Secretariat were:

Decision:	Strengthening diagnostics capacity
A. Link to the approved revised Programme budget 2022–2023	
1. Output(s) in the approved revised Programme budget 2022–2023 under which this draft decision would be implemented if adopted:	<p>1.3.1. Provision of authoritative guidance and standards on quality, safety and efficacy of health products, essential medicines and diagnostics lists.</p> <p>1.3.2. Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems.</p> <p>1.3.3. Country and regional regulatory capacity strengthened, and supply of quality-assured and safe health products improved, including through prequalification services.</p> <p>1.3.4. Research and development agenda defined and research coordinated in line with public health priorities.</p> <p>1.3.5. Countries enabled to address antimicrobial resistance through strengthened surveillance systems, laboratory capacity, infection prevention and control, awareness-raising and evidence-based policies and practices.</p> <p>2.1.2. Capacities for emergency preparedness strengthened in all countries.</p> <p>2.3.1. Potential health emergencies rapidly detected, and risks assessed and communicated.</p>
2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved revised Programme budget 2022–2023:	Not applicable.
3. Any additional Secretariat work during the biennium 2022–2023 that cannot be accommodated within the approved revised Programme budget 2022–2023 ceiling:	Zero.
4. Estimated time frame (in years or months) to implement the decision:	Seven years.
B. Resource implications for the Secretariat for implementation of the decision	
1. Total budgeted resource levels required to implement the decision, in US\$ millions:	US\$ 49.51 million.
2.a. Estimated resource levels required that can be accommodated within the approved revised Programme budget 2022–2023 ceiling, in US\$ millions:	US\$ 5.23 million.
2.b. Estimated resource levels required in addition to those already budgeted for in the approved revised Programme budget 2022–2023, in US\$ millions:	Zero.

3.	Estimated resource levels required to be budgeted for in the proposed programme budget for 2024–2025, in US\$ millions: US\$ 11.56 million.
4.	Estimated resource levels required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions: US\$ 32.72 million.
5.	Level of resources already available to fund the implementation of the decision in the current biennium, in US\$ millions – Resources available to fund the decision in the current biennium: US\$ 4.00 million. – Remaining financing gap in the current biennium: US\$ 1.23 million. – Estimated resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium: Zero.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2022–2023 resources already planned	Staff	0.36	0.26	0.27	0.27	0.26	0.27	3.06	4.75
	Activities	0.03	0.03	0.03	0.03	0.03	0.03	0.30	0.48
	Total	0.39	0.29	0.30	0.30	0.29	0.30	3.36	5.23
B.2.b. 2022–2023 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2024–2025 resources to be planned	Staff	0.77	0.57	0.59	0.59	0.57	0.59	6.64	10.32
	Activities	0.09	0.07	0.07	0.07	0.07	0.07	0.80	1.24
	Total	0.86	0.64	0.66	0.66	0.64	0.66	7.44	11.56
B.4. Future bienniums resources to be planned	Staff	2.26	1.68	1.73	1.73	1.66	1.73	19.44	30.23
	Activities	0.19	0.14	0.14	0.14	0.14	0.14	1.60	2.49
	Total	2.45	1.82	1.87	1.87	1.80	1.87	21.04	32.72

The representative of the REPUBLIC OF MOLDOVA said that growing disparities in access to essential health services should be addressed by removing unnecessary barriers to services and tackling the shortage of health workers, including by improving their working conditions and making use of new technologies to enhance, and potentially speed up, training. Particular attention should be given to strengthening the maternal and child health workforce, and to chronic diseases, which could be managed more efficiently through the use of smart technology. It was important to consider how to make primary

health care more technologically advanced and more attractive for both health workers and patients, with a view to achieving universal health coverage through strong national health systems.

The representative of RWANDA, speaking on behalf of the Member States of the African Region, commended the progress made towards achieving universal health coverage, despite the many ongoing challenges. The Member States of the Region supported the four priority areas for action identified in the report. To that end, WHO and its development partners should provide technical and financial support to develop evidence-based, contextualized approaches that would allow Member States to: get back on track in achieving universal health coverage; create costed national plans and packages as part of resource mobilization efforts; reform national health systems with a focus on primary health care; and build equity-oriented data and information capacities. Particular emphasis should be placed on supporting Member States to strengthen their commitment to primary health care through concrete actions and a whole-of-society approach; to increase resources for health, particularly domestic resources, and use them more efficiently, with targeted strategies to reach vulnerable populations; and to leverage COVID-19 pandemic recovery plans to improve the resilience of local health systems.

Concerning the alignment between the Health Assembly and the high-level meetings of the United Nations General Assembly on health, it was vital to take a coordinated, multisectoral and whole-of-government approach; action and investment up to 2030 should support country-specific priorities and national plans aimed at achieving the health-related Sustainable Development Goals. She asked for the Member States of the African Region to be added to the lists of sponsors of the draft decisions on increasing access to medical oxygen and on integrated emergency, critical and operative care for universal health coverage and protection from health emergencies.

The representative of DENMARK, speaking on behalf of the European Union and its Member States, said that the candidate countries North Macedonia, Montenegro, Serbia, Ukraine, the Republic of Moldova and Bosnia and Herzegovina aligned themselves with his statement. Strong, equitable and sustainably financed health systems were the backbone of quality primary health services, universal health coverage and global health security; efforts to strengthen those systems should address financing, governance, human resources, infrastructure, information systems, access to commodities, health monitoring and community participation. Indeed, no country could provide universal health coverage without essential public functions to protect and promote the health of populations. Furthermore, primary health services should be considered an essential part of health systems as a whole, rather than a functionally separate entity. They should be person-centred and encompass preventive, curative, rehabilitative and palliative services for communities and individuals. Other population-level functions, such as disease surveillance, could also be more efficiently organized at the national or subnational levels.

Primary health care should cover health promotion, with a focus on noncommunicable and communicable diseases, vaccination and infection prevention and control, as well as services that improved maternal, child and adolescent health, mental health, and sexual and reproductive health and rights, in accordance with the Beijing Platform for Action, the Programme of Action of the International Conference on Population and Development and paragraph 34 of the European Consensus on Development. As the first line of defence against epidemics and other health crises, primary health services should be sufficiently resilient to maintain the provision of essential services in emergency situations. In that regard, the community health workforce was essential to ensuring access to primary health care. Tackling the social and environmental determinants of health, as well as inequity and gender equality in health systems, was also a prerequisite for equitable health systems and universal health coverage, and social protection should be provided to guarantee access to health services without any risk of debt. Lastly, adequate, sustainable financing was needed, including through domestic health financing strategies based on the solidarity-based pooling of funds and according to national need.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND expressed concern over the lack of global progress towards universal health coverage, particularly in relation to financial protection. She supported the priority areas for action outlined in the report and noted that WHO's role in tracking progress and public health expenditure would be critical to prioritizing efforts. It was important to address shortages in the health workforce, particularly the lack of community health workers. Those shortages had been exacerbated by the COVID-19 pandemic, which had also exposed growing inequities in health; increased focus was therefore needed on equity, gender and inclusion to ensure that health coverage was truly universal. Her Government welcomed the development of the universal health coverage service package delivery and implementation tool and the OneHealth tool, and encouraged the Secretariat to continue expanding those tools, including through the integration of cost-effectiveness evidence. Member States should be supported in building their capacity to use those tools effectively, while buy-in from development partners and other entities of the United Nations system would also be essential.

She welcomed the proposed actions to shape a coherent narrative across the health-related high-level meetings of the United Nations General Assembly, stressing the need to maximize the political commitment to health and minimize competition between health agendas, which should be consolidated where possible. Lastly, it was vital to orient the international and regional health and finance architecture to support domestic resource mobilization for universal health coverage. She therefore endorsed efforts to convene global health and financing partners to explore sustainable, long-term investment in that area and establish a dialogue on Health for All as part of WHO's 75th anniversary.

The representative of the REPUBLIC OF KOREA said that the priority areas for action would be essential to achieve the Sustainable Development Goals, and that there should be a particular focus on promoting research that identified vulnerable groups in order to design more active policy interventions to address their needs. The Secretariat should therefore provide guidance to support Member States in building research, data and information systems suited to their respective context and priorities. Given the negative impact of the COVID-19 pandemic on mental health worldwide, related services and infrastructure should be strengthened through the provision of local, community-based primary health care. The Secretariat should work with Member States that had made the most progress towards universal health coverage to provide education and training in that regard. In the run-up to the high-level meeting of the United Nations General Assembly on universal health coverage, consideration should be given to holding an event linking the financial and health sectors with a view to promoting collective investment in that area.

The representative of TIMOR-LESTE, speaking on behalf of the Member States of the South-East Asia Region, said that the three high-level meetings of the United Nations General Assembly due to take place in 2023 presented a great opportunity to drive the global health agenda forwards. The issues of universal health coverage, tuberculosis and pandemic prevention, preparedness and response to be addressed at the high-level meetings were all interlinked, as highlighted in the draft decision on preparation for the high-level meeting of the United Nations General Assembly on universal health coverage. She urged Member States to support that draft decision, which also sought to ensure adequate investment and better allocation of resources for health and emphasized the importance of measuring unmet health needs. The feasibility of using unmet health needs as an additional indicator for monitoring universal health coverage could also be discussed during regional consultations held as part of WHO's broader review of progress on the health-related Sustainable Development Goals.

The representative of BRAZIL said that a lack of adequate financing and inefficient use of available resources were major challenges in achieving universal health coverage and called for more funding to universalize access to health services, including through comprehensive primary health care. It was important to strengthen international cooperation and ensure that both national and international health financing commitments were honoured. Efficient and participatory health systems required

commitment from society, with clear mechanisms for inclusion, transparency and accountability, as well as multisectoral participation and dialogue with the various social actors; his own Government had taken that approach in national initiatives. It was also essential to address the needs of and challenges faced by the health workforce, which was key to achieving universal health coverage. He hoped that the upcoming high-level meeting of the United Nations General Assembly on universal health coverage would lead to concrete actions towards expanding local production and affordable access to medical products and technologies; the draft decision on preparation for that meeting represented an important step towards reaching consensus on an associated political declaration. He expressed support for the other three draft decisions under discussion.

The representative of YEMEN, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that a strategy had been adopted at the Sixty-ninth Session of the Regional Committee to build more resilient health systems with a view to achieving universal health coverage and improving health security. The Region faced significant challenges, which often required different solutions from those applied in other regions. Particular support was needed to develop service delivery models that were tailored to the specific circumstances of individual countries, based on lessons learned at the international level. Health financing was another area requiring support, particularly in terms of developing appropriate strategies to strengthen financial protection mechanisms. He thanked the Secretariat for the support provided thus far to identify priority regional benefits packages for the delivery of universal health coverage, and the Regional Office for its work to strengthen family medicine programmes alongside the World Organization of Family Doctors and the Arab Board of Health Specializations.

Speaking in his national capacity, he stressed the importance of a high-level coordination mechanism to support efforts to achieve universal health coverage, especially in the context of crises, insufficient government commitment and low budgets. Attaining the health-related Sustainable Development Goals required the mobilization of both domestic and international resources and support, particularly in low-income countries, countries affected by armed conflict and countries under the threat of health emergencies. Budgetary challenges were heightened further in countries such as Yemen, where large numbers of internally displaced persons represented a great burden on already fragile health systems. Although some progress had been made to improve primary health care provision nationally, additional support was needed. Increased support was also needed in the area of health information systems and data collection. He hoped that strong political commitment could be secured at the high-level meeting of the United Nations General Assembly on universal health coverage.

The representative of CANADA said that the shift towards the endemic management of COVID-19 represented an opportunity to refocus attention on investment in primary health care and health systems strengthening as a means to achieve universal health coverage and strengthen global health security. Integrated and fully accessible sexual and reproductive health services were a fundamental component of universal health coverage and critical to achieving the Sustainable Development Goals; diagnostics capacity was similarly crucial to ensure a strong health system. The Secretariat should continue to play a key role by providing technical and policy support to Member States; to that end, it was positive to see that a radical reorientation of health systems towards primary health care as the foundation of universal health coverage had been included in the proposed programme budget for 2024–2025. He asked how the Secretariat's support to Member States would evolve in line with that approach. The high-level meeting of the United Nations General Assembly on universal health coverage represented an opportunity to join forces to develop a concise, action-oriented, consensus-based political declaration; WHO could provide technical expertise and play an important role in that endeavour, with the Secretariat supporting the preparatory process.

The representative of BOTSWANA said that WHO, other entities of the United Nations system and development partners should support the creation of an investment case for the health sector as an

advocacy tool that could be used to demonstrate value while identifying gaps in provision. That would inform the identification of priorities and help focus investment. In addition, the documentation and institutionalization of high-impact, evidence-based interventions would allow the effective and efficient delivery of primary health care at the national, regional and global levels, and facilitate South–South and South–North exchanges of knowledge and best practice. He supported the four draft decisions.

The representative of the UNITED STATES OF AMERICA said that universal health coverage would serve as a strong foundation for addressing future pandemics. It was therefore positive that the draft decision on preparation for the high-level meeting of the United Nations General Assembly on universal health coverage underscored the importance of coordination across all three high-level meetings on health to take place in 2023. Indeed, political leadership was key to building strong, comprehensive resilient health systems with primary health care as a fundamental component, and Member States should recommit to investing in essential health services, including sexual and reproductive health services, to accelerate collective progress towards universal health coverage. Additional efforts and cooperation were also needed to ensure that historically marginalized and excluded populations were able to access those services. Her Government was pleased that the draft decision on preparation for the high-level meeting highlighted the linkages between climate change and health; engagement with all stakeholders and sectors was needed in the preparations for the upcoming high-level meetings on health. She asked to be added to the list of sponsors of the draft decision on increasing access to medical oxygen. She expressed support for the draft decision on strengthening diagnostics capacity and looked forward to further discussions on equitable access to diagnostics during deliberations of the Intergovernmental Negotiating Body to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response and in other forums. However, it was regrettable that the content of previous informal consultations on the subject had been leaked to the media; Member States should respect the confidential nature of informal negotiations.

The representative of ETHIOPIA called on Member States to support the draft decision on integrated emergency, critical and operative care for universal health coverage and protection from health emergencies, which addressed the gaps identified and lessons learned during the COVID-19 pandemic and would improve preparedness for future health challenges, while also contributing to the realization of universal health coverage. WHO's 75th anniversary was as an opportunity to catalyse additional efforts in that regard. Lastly, she expressed support for the draft decisions on increasing access to medical oxygen and on strengthening medical diagnostics capacity.

The representative of the RUSSIAN FEDERATION agreed that primary health care was key to achieving universal health coverage, as established by the Declaration of Alma-Ata and the Declaration of Astana. The Secretariat and Member States should continue to be guided by the principles of those declarations and use new data and evidence-based approaches to reduce inequalities in access to health services. The Russian health care system was proof that universal health coverage could be achieved. The COVID-19 pandemic had shown the importance of ensuring unhindered access to prevention, diagnostic and treatment services. It was therefore surprising that some Member States had not supported the inclusion of that concept in the draft decision on strengthening diagnostics capacity, the final draft of which was not aligned with the previous references to “unhindered access” in resolutions WHA74.7 and WHA73.1. She hoped that the draft decision would still enable progress towards the Organization's goals, despite being weakened by those omissions.

The representative of MALDIVES expressed support for the priority areas for action described in the report and welcomed the development of an integrated health tool for national strategic health planning and costing. Given the high costs of social health insurance models for countries, it was necessary to achieve a balance between public financing and out-of-pocket expenditure, while

improving efficiencies and health outcomes, and minimizing wastage. She therefore asked development partners to provide technical support in developing domestically sustainable financing mechanisms suited to small island developing States and other resource-deficient countries. Global and regional partnerships were also needed to ensure cost-effective and sustainable access to research, and medical technology and products, particularly in resource-deficient countries. Support from the Secretariat should be focused on the development of health information systems and effective health data governance mechanisms to track inequities, in addition to capacity-building and coordination activities more generally. During preparations for the high-level meetings of the United Nations General Assembly on health, a coordinated and harmonized Health in All Policies approach would be necessary to reaffirm collective commitment to universal health coverage and achieve the related targets. Her Government therefore supported the draft decision on preparation for the high-level meeting of the United Nations General Assembly on universal health coverage.

The representative of MADAGASCAR drew attention to the health challenges faced in his country and outlined national measures aimed at achieving universal health coverage. However, those efforts required further support, as resources were limited. More specifically, the Secretariat should help his Government to develop evidence-based approaches and tools, mobilize resources, coordinate multisectoral action, and establish a basket fund to improve infrastructure and equipment.

The representative of GHANA expressed concern that global progress was not on track to achieve the targets related to universal health coverage by 2030. His Government supported the priority areas for action outlined in the report and called on the Secretariat to help his Government to implement its flagship networks of practice strategy. Further advocacy and increased resources were needed to strengthen the commitment to primary health care and promote a whole-of-society approach to its implementation.

The representative of CHINA asked to be added to the list of sponsors of the draft decision on integrated emergency, critical and operative care for universal health coverage and protection from health emergencies and called on Member States to support that draft decision as well as the draft decision on preparation for the high-level meeting of the United Nations General Assembly on universal health coverage. During health emergencies, when a surge in medical needs threatened the provision of public health services, the Secretariat should play a vital role by providing evidence-based support to help Member States to adapt services and prioritize resource allocation in order to maintain the delivery of effective primary health care. Noting the importance of primary health care as a tool for achieving universal health coverage and the Sustainable Development Goals, his Government stood ready to share, with help from WHO, the steps it had taken to improve services in rural areas and prevent impoverishing health spending. The COVID-19 pandemic had shown that promoting unhindered, equitable access to safe, high-quality and affordable diagnostic tools and medical products and services was key to an effective response. His Government therefore supported efforts to increase accessibility and local production capacity, especially in developing countries. During consultations, Member States should respect earlier resolutions that had been adopted by consensus.

The representative of MALAYSIA welcomed the priority areas for action identified in the report and shared several national measures taken with a view to achieving universal health coverage and reducing out-of-pocket health care spending, including the establishment of partnerships with the private sector to improve screening services.

The representative of JAPAN welcomed the inclusion of research, data and information systems in the priority areas for action, as they were vital to both increasing equity and enhancing the efficiency of health systems and services. In the light of the slowing of progress caused by the COVID-19 pandemic, his Government supported the renewal of efforts to achieve universal health coverage,

particularly those to build partnerships between finance and health ministries. Currently holding the G7 presidency, his Government was committed to advancing universal health coverage at high-level meetings and supported the draft decision on preparation for the high-level meeting on universal health coverage. He encouraged Member States to align those efforts with work preparations for the other two high-level meetings on health due to take place in 2023 and to speak with one voice to maximize efficiency and impact.

The representative of the SYRIAN ARAB REPUBLIC, expressing concern regarding the major disparities in service coverage between rich and poor households, stressed that obstacles in accessing medical products and diagnostic tools increased inequity and harmed health systems. She supported the draft decisions but expressed reservations regarding the draft decision on strengthening diagnostics capacity, which did not fully reflect the views voiced by Member States during consultations. Her delegation had wished to see a reference to unhindered access to diagnostic tools, on the basis of language agreed upon in past resolutions, notably WHA73.1 and WHA74.7. It was unclear why certain Member States had refused to include that previously agreed language in the draft decision, thus preventing those concerns from being expressed. However, despite those reservations, her Government was prepared to join the consensus with a view to achieving the overall objective of ensuring unhindered access to diagnostic tools and other health products in developing countries.

The representative of SLOVENIA drew attention to his country's long experience in integrating primary health care into broader public health services, including through strong community engagement to address the determinants of health and improve access to health services for the most vulnerable populations. Social participation and collaboration with civil society were key to ensuring that no one was left behind and should be implemented globally. A strong health workforce was also needed to attain universal health coverage; health professionals, and particularly women, should be involved in decision-making and other efforts to address staff shortages caused by the migration of health workers, as ownership by stakeholders was essential in the implementation of solutions.

The representative of FRANCE said that the consequences of the COVID-19 pandemic called for the mobilization of actors at all levels to ensure sustainable, large-scale investment in resilient, equitable health systems and universal, solidarity-driven social protection mechanisms. That was the only way of guaranteeing high-quality health care for all and international health security. Reaffirming his Government's commitment to universal health coverage, he stressed the importance of actions to strengthen health systems in all international bodies and multilateral funding mechanisms. Achieving universal health coverage would also strengthen pandemic prevention, preparedness and response. He welcomed the vital advocacy and monitoring work of the UHC2030 platform and called for effective coordination across the three high-level meetings of the United Nations General Assembly on health.

The representative of AFGHANISTAN highlighted the diverse needs of countries at different stages of development, especially those experiencing high levels of fragility and conflict. In cases where national governments were unable to fulfil their commitments in relation to the population's health, especially at the secondary and tertiary levels, humanitarian agencies often focused on short-term life-saving interventions at the programmatic level, which further undermined national health systems. In his country, international aid tended to be allocated solely to primary health care, which opened up gaps in other areas, such as the treatment of noncommunicable diseases. Although he supported the focus on primary health care as a path towards universal health coverage, resources and strategies should address the health care continuum as a whole, with a balance between preventive and curative services to reflect requirements in different contexts. Furthermore, universal health coverage would not be possible while women and girls were unable to access education, as was currently the case in Afghanistan. He therefore called on the Board to advocate for medical education as a step towards global access to education and work for Afghan women and girls.

The representative of COLOMBIA said that national plans for the public financing of health systems oriented to primary health care, based on a multisectoral and multilateral approach, represented a virtuous circle in guaranteeing the right to health. Health services should be universal, free at the point of use and integrated across the life course. The right to health should also be considered in relation to other rights, notably the right to decent working conditions for health workers, who were being placed in increasingly precarious and dangerous situations. Universal health systems must be person-centred, participative and non-discriminatory, recognizing differences in terms of ethnicity, gender, sexuality and disability, among other things. Adequate social security systems were also needed to prevent the use of commercial insurance policies, which only deepened social and health inequities. The challenge was therefore to build robust, autonomous health care systems that guaranteed fundamental rights and were not threatened by monopolistic economic interests. Particular attention should be given to equity in research, innovation and development, as well as efforts to mitigate and adapt to climate change.

The representative of INDIA, observing that universal health coverage had been identified as a priority area for action as part of his Government's presidency of the G20, highlighted the importance of evidence-based traditional medicine in promoting holistic health care and well-being as part of primary health care. Access to safe and affordable medical products was key to achieving universal health coverage, and models to facilitate such access needed to be strengthened. Innovation and technology also played an essential role, especially during health emergencies. The concept of global digital public health goods should therefore be promoted to allow the integration of digital tools into primary health care systems. Noting that community engagement and increased diagnostics capacity could minimize the impact of pandemics, he called for support to enable Member States to transform their pandemic response measures into sustainable interventions, which should include community-based surveillance, diagnostics and vaccine administration mechanisms. Efforts were also needed to train and upskill human resources for health.

The representative of PERU noted the importance of population coverage, service coverage and financial coverage in achieving universal health coverage, observing that financial protection was key to reducing out-of-pocket health care spending. With regard to population coverage, the Secretariat should share successful examples of health observatories undertaking effective surveillance and monitoring to identify risk profiles for diseases and monitor the healthy population in a cost-effective manner. It would also be useful to establish a shared definition of the concept of primary health care, with clear and transparent parameters to facilitate comparison of the health systems and budgets of different Member States. In addition, primary health care policies and budgets should pay greater attention to healthy populations and those that were not using health care services. During the COVID-19 pandemic, many people had died from preventable and controllable chronic conditions due to a delay in intervention; a paradigm shift was needed within primary health care to identify the most cost-effective ways to improve outcomes in such cases. His Government supported the four draft decisions.

(For continuation of the discussion and adoption of decisions, see the summary records of the sixth meeting, section 2.)

The meeting rose at 13.05.

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