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Executive Board

158th session

Geneva, 2–6 February 2026

Resolutions and decisions

Annexes

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Abbreviations

Abbreviations used in WHO documentation include the following:

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

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Preface

The 158th session of the Executive Board was held at WHO headquarters, Geneva, from 2 to 6 February 2026. The proceedings are issued in two volumes. The present volume contains the resolutions and decisions, and relevant annexes. The summary records of the Board's discussions, and details regarding membership of committees, are issued in document EB158/2026/REC/2. The list of participants and officers is contained in document EB158/DIV./1 Rev.1.



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⁹ See Annex 5.

¹⁰ See Annex 1.

Resolutions

EB158.R1 Steatotic liver disease: a missing piece in the global noncommunicable disease response¹

The Executive Board,

Having considered the report of the Director-General,²

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

The Seventy-ninth World Health Assembly,

Having considered the report by the Director-General on universal health coverage;

Recognizing that steatotic liver disease, formerly referred to as fatty liver disease, comprises metabolic dysfunction-associated steatotic liver disease, including its more severe inflammatory form, metabolic dysfunction-associated steatohepatitis; alcohol-associated liver disease; and metabolic dysfunction-associated steatotic liver disease combined with increased alcohol intake,^{3,4} and is one of the fastest-growing causes of chronic liver disease, affecting about 1.7 billion people worldwide with substantial prevalence across age groups, with prevalence projected to increase further in parallel with the global rise in obesity, type 2 diabetes and other metabolic risk factors, and in the context of the continued global public health burden of harmful use of alcohol;^{3,5}

Noting with concern that steatotic liver disease encompasses a spectrum of chronic liver disease, with documented risk of progression particularly in higher risk groups, to steatohepatitis and fibrosis which, in some cases may progress to cirrhosis and even liver cancer;

Recognizing that morbidity and mortality related to steatotic liver disease are driven by modifiable risk factors common to major noncommunicable diseases, including but not limited to unhealthy diets, obesity, physical inactivity, tobacco use and the harmful use of

¹ See Annex 5 for the financial and administrative implications for the Secretariat of this resolution.

² Document EB158/6.

³ Rinella ME, Lazarus JV, Ratziu V, Francque SM, Sanyal AJ, Kanwal F, et al., [A multisociety Delphi consensus statement on new fatty liver disease nomenclature](#). Journal of Hepatology. 2023; 79, 1542-1556. doi.org/10.1016/j.jhep.2023.06.003.

⁴ Younossi ZM, Kalligeros M, Henry L. [Epidemiology of metabolic dysfunction-associated steatotic liver disease](#). Clin Mol Hepatol. 2025;31(Suppl): S32-S50. doi.org/10.3350/cmh.2024.0431.

⁵ [Global status report on alcohol and health 2018](#). Geneva: World Health Organization; 2018 (accessed 25 March 2026).

alcohol, and noting emerging evidence of additional contributing factors, and further recognizing that steatotic liver disease is closely associated with type 2 diabetes, cardiovascular disease, chronic kidney disease and other metabolic conditions, thereby amplifying the overall burden of noncommunicable diseases and underscoring the need for integrated and comprehensive public health responses;

Acknowledging that steatotic liver disease is a leading cause of liver-related morbidity and mortality, and a major indication for liver transplantation in high-income countries,⁶ while also imposing a rapidly rising burden in developing countries where early detection, diagnostic and treatment capacity remain constrained by broader health systems resource challenges;

Expressing concern at new projections indicating a marked and continuing increase in the global burden of steatotic liver disease, including progression to decompensated advanced chronic liver disease and liver cancer, as well as rising demand for specialized care, with serious implications for health systems worldwide;⁷

Noting with concern the increasing prevalence of steatotic liver disease among children and adolescents, particularly in association with rising rates of childhood obesity, unhealthy dietary patterns and physical inactivity, which may lead to long-term consequences for health, human capital and sustainable development, particularly in resource constrained settings;

Recognizing that steatotic liver disease has substantial economic consequences, associated with increased healthcare expenditures, as well as the possible reduction of productivity and long-term disability, which places additional burden on health systems and disproportionately affects populations, including those facing limited access to affordable and equitable care and to health-promoting environments, thereby exacerbating existing health inequities;

Noting the under-recognition, under-diagnosis, and limited availability of data of steatotic liver disease within national health systems and globally, which hinders timely prevention, early detection and treatment, thereby exacerbating existing health inequities, particularly in developing countries;

Noting also that limited awareness of steatotic liver disease among policy-makers, health professionals and the public contributes to under-diagnosis, late presentation, limited integration within noncommunicable disease programmes and challenges in resource allocation;

Recalling United Nations General Assembly resolution 68/300 (2014) and, in particular, United Nations General Assembly resolution 70/1 (2015) on transforming our world: the 2030 Agenda for Sustainable Development, which includes Sustainable Development Goal

⁶ Younossi ZM, Kalligeros M, Henry L. [Epidemiology of metabolic dysfunction-associated steatotic liver disease](#). Clin Mol Hepatol. 2025;31(Suppl): S32-S50. doi.org/10.3350/cmh.2024.0431.

⁷ Estes C, Razavi H, Loomba R, Younossi ZM, Sanyal AJ. [Modeling the epidemic of nonalcoholic fatty liver disease demonstrates an exponential increase in burden of disease](#). Hepatology. 2018; 67(1), 123–133. doi.org/10.1002/hep.29466.

target 3.4 to, by 2030, reduce premature mortality from noncommunicable diseases by one third through prevention and treatment against a baseline of 2015;

Recalling also, as appropriate, the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, adopted through United Nations General Assembly resolution 73/2 (2018), which called for intensified actions on noncommunicable disease prevention and control and the shared risk factors, and emphasized the urgency of accelerating the implementation of evidence-based, cost-effective interventions, strengthening accountability and monitoring, and advancing equity-focused integrated health responses;

Recalling, as appropriate, the political declaration of the fourth high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases and the promotion of mental health and well-being, adopted through United Nations General Assembly resolution 80/117 (2025), which commits Member States to take actions towards preventing liver cancer and other liver diseases, including through scaling up hepatitis B and C prevention, diagnosis and treatment, hepatitis B vaccination, strengthening monitoring for early detection of liver cancer, and improving survival, as well as strengthening screening and management for non-alcoholic fatty liver disease, referred to in the context of this resolution as steatotic liver disease;

Recalling, as appropriate, decision WHA72(11) (2019) on follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, which confirmed the objectives of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020⁸ as a contribution towards the achievement of Sustainable Development Goal target 3.4, and extended its implementation to 2030 in alignment with the 2030 Agenda for Sustainable Development;

Recalling also, as appropriate, the political declaration of the high-level meeting on universal health coverage, adopted through General Assembly resolution 74/2 (2019), which included the commitment to progressively cover one billion additional people by 2023 with quality essential healthcare services and safe, effective, affordable and quality essential medicines, vaccines, diagnostics and health technologies, with a view to covering all people by 2030, and the political declaration of the high-level meeting on universal health coverage, adopted through United Nations General Assembly resolution 78/4 (2023), which reaffirmed the importance of integrated health responses, and the commitment to leave no one behind;

Emphasizing the importance of life-course approaches, primary healthcare, and universal health coverage as enablers for effective health promotion, prevention, and management of steatotic liver disease within the broader noncommunicable diseases agenda;

Recognizing the need to invest in research and innovation, including digital health solutions, public health measures on health promotion and disease prevention, within a common noncommunicable disease risk factors approach, timely diagnostics, and evidence based and cost-effective interventions, that take into account heterogeneity of steatotic liver

⁸ See document WHA66/2013/REC/1, resolution WHA66.10 and Annex 4.

disease, together with strengthened health information systems, to improve national and global responses to steatotic liver disease, in line with individual and population health needs;

Emphasizing also the need for integrated, evidence-based, whole-of-government and whole-of-society approaches to the prevention and control of steatotic liver disease, including policies to promote healthy diets, increase physical activity, reduce excessive levels of saturated fats and free sugars, alcohol strategies, interventions and policies in line with the WHO global alcohol action plan 2022–2030 to effectively implement global strategies to reduce harmful use of alcohol as a public health priority, while addressing the social and environmental determinants of health and the impact of economic, commercial and market factors in health through coherent and multisectoral policy actions, in line with national priorities and capacities;

Recognizing the importance of the ongoing work of the World Health Organization, in collaboration with Member States and relevant stakeholders, to support evidence-based and cost-effective actions on noncommunicable diseases and metabolic conditions, and its relevance for steatotic liver disease prevention and control within these efforts,

1. ENCOURAGES Member States:⁹

- (1) to take actions on steatotic liver disease, in accordance with national contexts and priorities, and consistent with existing commitments under the relevant United Nations political declarations on noncommunicable diseases and universal health coverage;
- (2) to integrate, or where already in place, continue to integrate steatotic liver disease into national noncommunicable diseases strategies, action plans and monitoring frameworks, ensuring policy coherence and alignment with commitments to accelerate efforts towards achieving Sustainable Development Goal target 3.4 by 2030, as appropriate, to national epidemiological and health system contexts;
- (3) to strengthen multisectoral action addressing shared risk factors of steatotic liver disease and other noncommunicable diseases, including through legislative and regulatory measures that promote healthy diets, increase physical activity, reduce excessive levels of saturated fats and free sugars, alcohol strategies, interventions and policies in line with the WHO global alcohol action plan 2022–2030 to effectively implement global strategies to reduce harmful use of alcohol as a public health priority, and as appropriate, the application of WHO best buy interventions;¹⁰
- (4) to incorporate, or continue to undertake, health promotion, and steatotic liver disease prevention, screening, early detection, diagnosis and management into essential healthcare service packages within universal health coverage, with a focus on primary healthcare, equity and access, and phased implementation based on national capacity;
- (5) to increase awareness and education initiatives on steatotic liver disease among policy-makers, health professionals and the public, reducing stigma and empowering people and communities to adopt healthier lifestyles;

⁹ And, where applicable, regional economic integration organizations.

¹⁰ [Tackling NCDs: best buys and other recommended interventions for the prevention and control of noncommunicable diseases, second edition](#). Geneva: World Health Organization; 2024 (accessed 25 March 2026).

- (6) to develop, as appropriate, national investment cases for steatotic liver disease within the broader noncommunicable disease agenda, highlighting the economic burden, health inequities and return on investment of prevention and control measures;
- (7) to strengthen national surveillance, monitoring and accountability mechanisms for steatotic liver disease, as well as national reporting, in alignment with existing noncommunicable disease frameworks and Sustainable Development Goal processes, while avoiding duplication of systems;
- (8) to strengthen health systems, particularly through primary healthcare, to ensure universal access to affordable, high-quality and comprehensive healthcare services for people living with steatotic liver disease, with particular attention to children;
- (9) to continue to invest in research and innovation, including digital health solutions and cost-effective tools for steatotic liver disease screening, prevention, diagnosis and management, with the aim of addressing individual and population health needs, and to enhance equitable access to affordable, safe, effective and quality-assured diagnostics, therapeutics and technologies, respecting international rules and national rules in line therewith;
- (10) to foster collaboration among policy-makers, governmental health and research authorities, academic institutions, clinicians, patient organizations, the private sector and civil society, taking into account the need to prevent conflicts of interest, to advance comprehensive actions on steatotic liver disease prevention and control, promote knowledge-sharing and innovation, strengthen accountability, and ensure that such collaboration is consistent with global actions on noncommunicable diseases, national health priorities, and the 2030 Agenda for Sustainable Development;
- (11) to raise awareness regarding steatotic liver disease and its risk factors within relevant multilateral forums, to ensure sustained and concrete political attention, and explore ways to integrate steatotic liver disease into health policies and programmes, in line with national strategies and priorities;
- (12) to regularly assess, where applicable, the implementation of national action plans for noncommunicable diseases including steatotic liver disease and, to the extent possible, review their contribution to the implementation of global and regional action plans related to noncommunicable diseases;

2. REQUESTS the Director-General:

- (1) to integrate steatotic liver disease within the broader context of noncommunicable diseases prevention, early detection and management, and to strengthen ongoing multisectoral collaboration on steatotic liver disease through a whole-of-society approach, including through the implementation of WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2030 and its road map;
- (2) to provide, in line with WHO's Fourteenth General Programme of Work, 2025–2028 and prioritized functions, technical support to Member States, upon request, to strengthen integrated steatotic liver disease services within current healthcare service delivery models, workforce capacity, surveillance systems and referral pathways, with particular attention to developing countries and populations at higher risk;

- (3) to support Member States by promoting the use of existing WHO guidance and operational tools relevant to steatotic liver disease, and facilitating their integration across relevant technical areas, as appropriate;
- (4) to integrate steatotic liver disease into ongoing efforts to strengthen global, regional and national collaboration with relevant partners, academic institutions and civil society, in line with Framework of Engagement with Non-State Actors, as applicable, to mobilize resources, foster research and innovation, promote equitable access to diagnostics, medicines and digital tools, and to facilitate the exchange of technologies for noncommunicable diseases and relevant to steatotic liver disease, respecting international rules;
- (5) to continue exercising WHO's leadership and coordination, within existing WHO mandates, in noncommunicable disease prevention and control including through WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2030, the WHO strategic approach to address cardiometabolic condition and other frameworks, as appropriate, across relevant WHO programmes;
- (6) to report biennially on the implementation of this resolution to the World Health Assembly through the report submitted in response to decision WHA72(11) (2019) on the follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, adopted through United Nations General Assembly resolution 73/2 (2018), which will also cover the outcome of the fourth high-level meeting of the General Assembly on the prevention and control of non-communicable diseases and the promotion of mental health and well-being, on the progress made in addressing steatotic liver disease as part of the global noncommunicable disease agenda.

(Third meeting, 3 February 2026)

EB158.R2 Precision medicine: a path towards targeted, personalized and equitable care¹¹

The Executive Board, having considered the reports by the Director-General on universal health coverage,

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

The Seventy-ninth World Health Assembly,

Having considered the report by the Director-General,

Acknowledging the rapid evolution of biomedical and digital health sciences, including genomics, proteomics, pharmacogenomics, bioinformatics, real-world data analytics, molecular diagnostics, and advanced therapies such as cell and gene therapies, and recognizing the cross-cutting and enabling role of artificial intelligence in supporting these domains, which collectively underpin precision medicine and have the potential to transform prevention, diagnosis and treatment across the life course;

¹¹ See Annex 5 for the financial and administrative implications for the Secretariat of this resolution.

Recognizing that the term “precision medicine” refers to the use of clinical, molecular, genomic, and other health-related data to inform prevention, diagnosis and treatment decisions, taking into account individual variability in clinical characteristics, molecular and genomic profiles with appropriate safeguards, including the use of health technology assessment, to promote ethical, equitable and cost-effective implementation and improved health outcomes;

Recognizing also that precision medicine represents a paradigm shift towards predictive, preventive and participatory health systems, enabling targeted, effective and efficient interventions that enhance the efficiency and sustainability of universal health coverage by ensuring that the right intervention reaches the right patient at the right time;

Recognizing further that precision medicine, through genomic sequencing, high-throughput diagnostics and molecular targeting, and through the development and delivery of advanced therapies such as cell and gene therapies, has shown measurable clinical benefit, and in several cases demonstrated cost-effectiveness, including by improving survival through targeted cancer therapies, shortening the diagnostic odyssey for rare diseases, and reducing adverse drug reactions through pharmacogenomics;

Recognizing the contribution of precision medicine to the prevention and management of noncommunicable diseases, infectious diseases, maternal, child, and mental healthcare, and its potential to improve health outcomes and greater health system efficiency;^{12,13,14}

Noting that global investment in precision medicine is projected to grow substantially by 2030, reflecting its growing impact on clinical innovation, biotechnology and public health, and the need to foster such investment to yield equitable and sustainable benefits across all regions;^{15,16}

Recalling, as appropriate, the 2023 United Nations high-level meeting on universal health coverage and the 2030 Agenda for Sustainable Development, including commitments to promote equitable distribution of and increased access to quality, safe, effective, affordable and essential medicines, vaccines, diagnostics and health technologies, as enablers of affordable, quality healthcare services and their timely delivery for all throughout the life course;

¹² Liang S, Kennedy E, Gale N, Watson P, Ramanathan M, Shinde A, et al. Implementation of precision medicine in treating non-communicable diseases: a systematic review. *Journal of Translational Medicine*: 23, 1174 (2025). doi: 10.1186/s12967-025-07201-y.

¹³ Strianese O, Rizzo F, Ciccarelli M, Galasso G, D’Agostino Y, Salvati A, et al. Precision and personalized medicine: how genomic approach improves the management of cardiovascular and neurodegenerative disease. *Genes*. 2020 July;11(7):747. doi: 10.3390/genes11070747.

¹⁴ [Precision health: emerging innovations for children and adolescents](#). Insight Report No.3. New York: UNICEF; 2024 (accessed 31 January 2026).

¹⁵ [Global precision medicine market size and outlook, 2023–2030](#). Grand View Horizon Databooks (accessed 31 January 2026).

¹⁶ [Precision medicine market size, share and trends analysis report, 2025–2033](#). Straights Research (accessed 31 January 2026).

Recognizing the role of precision medicine in advancing universal health coverage and the WHO Fourteenth General Programme of Work, 2025–2028, particularly in strengthening primary healthcare, ensuring equity and addressing health inequalities;

Recognizing also that many populations, particularly women, children and older adults, remain underrepresented in the data and research that underpin precision medicine, and emphasizing the need to ensure diversity and inclusivity in the research and application of precision medicine, including meaningful representation of developing countries and historically underrepresented regions, so that emerging approaches equitably benefit all populations;

Reaffirming the importance of deliberate and well-coordinated global and national efforts to ensure that advances in precision medicine contribute to reducing inequities and health disparities within and between countries, narrowing the digital divide and promoting equitable access to affordable and timely care;

Noting that current global capacities remain uneven, with developing countries facing limited laboratory infrastructure, underrepresentation in genomic and clinical datasets, shortage of skilled professionals, and inadequate governance mechanisms for ethical data use and sharing;^{17,18,19,20}

Conscious of the ethical, legal, social and economic implications of precision medicine, including patient privacy, informed consent, governance and stewardship of genetic and health data, respecting national laws, data protection and data sovereignty, algorithmic bias, and equitable access to innovation;

Recalling resolution WHA57.13 (2004) on genomics and world health, which urged Member States to strengthen capacity in genomics to improve health outcomes and to ensure that advances in this field are used ethically, equitably and for the benefit of all populations;

Recognizing also that the evolution of genomics and related biotechnologies, and the significant drop in costs in genome sequencing since the adoption of that resolution, has led to the emergence of precision medicine, offering new opportunities to translate scientific

¹⁷ Girisha K and Moosa S. Genomic testing in low- and middle-income countries (LMIC). *European Journal of Human Genetics*, 2024: 32;119394. doi: 10.1038/s41431-024-01622-x.

¹⁸ Corpas M, Pius M, Poburennaya M, Guio H, Dwek M, Nagaraj S, et al. Bridging genomics' greatest challenge: The diversity gap. *Cell Genomics*: 2025;5(1):100724. doi: 10.1016/j.xgen.2024.100724.

¹⁹ [Health researcher \(in full-time equivalent\) per million inhabitants, by WHO region \(first set of charts\)](#). World Health Organization, August 2025 (accessed 31 January 2026).

²⁰ [Guidance for human genome data collection, access, use and sharing](#). Geneva: World Health Organization; 2024 (accessed 31 January 2026).

discovery into equitable, needs-based and data-driven healthcare, at both the individual and population levels;^{21,22,23}

Recalling resolution WHA78.11 (2025) on rare diseases: a global health priority for equity and inclusion, which recognizes the importance of early diagnosis, equitable access to treatment and the inclusion of persons living with rare diseases;

Recalling also WHO's global strategy on digital health 2020–2027 and related initiatives on data governance, artificial intelligence and innovation, and recognizing their relevance in supporting the safe, ethical and equitable integration of precision medicine into health systems;

Recalling also the 2022 report of the WHO Science Council on accelerating access to genomics for global health, which calls for, inter alia, equitable integration of precision technologies to reduce health disparities, and the WHO's normative and technical guidance on human genome editing, digital health ethics and data governance, which offers a foundational policy framework for the responsible implementation of precision medicine;

Emphasizing the urgent need to strengthen national and regional capacities in genomics, pharmacogenomics, digital infrastructure, bioinformatics, clinical research, regulatory sciences and data governance, especially in developing countries, while ensuring transparency, data privacy and security, and to promote safe and secure access to that data, data health literacy and public engagement to build trust;

Emphasizing that effective and equitable implementation of precision medicine requires robust governance, skilled human resources, interoperable and secure data systems, sustainable financing and meaningful social participation, ensuring that no one is left behind;

Noting with appreciation the initiatives of Member States and regional bodies that enhance collaboration, research and equitable access to precision medicine and data-driven public health solutions,

1. URGES Member States,²⁴ in accordance with national contexts and priorities:

- (1) to develop, implement and strengthen national policies and strategies that promote precision medicine, aligned with universal health coverage goals and ethical standards, ensuring affordability, accessibility, equity and sustainability;
- (2) to recognize precision medicine as an important enabler of universal health coverage, where appropriate and cost-effective, and to integrate it into health system strengthening efforts, encompassing prevention, early detection, diagnosis, treatment

²¹ [Measuring genome sequencing costs and its health impact](#). Geneva: World Intellectual Property Organization; 19 March 2025 (accessed 31 January 2026).

²² Ehman M, Sharma K, Weymann D, Maroilley T, Mohajeri A, Lehman A, et al. The cost and cost trajectory of genome sequencing and bioinformatics analysis for Indigenous children with suspected rare diseases. *Genetics in Medicine*. 2025;27(11):101568. doi:10.1016/j.gim.2025.101568.

²³ [The cost of sequencing a human genome](#). National Human Genome Research Institute; 2021 (accessed 31 January 2026).

²⁴ And, where applicable, regional economic integration organizations.

and monitoring, paying particular attention to primary healthcare, as well as cancer control, rare diseases, noncommunicable diseases, infectious diseases, maternal and child health, and mental health and other nationally identified priority health areas;

(3) to strengthen national and regional capacities by investing in laboratory and diagnostic infrastructure, genomic databases, digital health platforms and relevant technologies, including artificial intelligence and biomedical engineering, to support the implementation and integration of precision medicine with the respect of national data sovereignty;

(4) to promote the inclusion of all populations in research, data systems and evaluation frameworks that support precision medicine, paying particular attention to women, children and older adults, and to address underrepresentation within the data, consistent with ethical standards, including appropriate informed consent, ensuring that approaches and interventions are rigorously assessed for safety and effectiveness across all populations and equitably benefit them;

(5) to establish, strengthen or maintain legal, ethical and regulatory frameworks that ensure effective data governance, privacy, transparency, interoperability, security and quality assurance, and that ensure the responsible, equitable and sustainable integration of precision medicine into national health systems, as well as enhance equitable access to innovations;

(6) to foster capacity-building through comprehensive education and training programmes in genomics, data science, bioinformatics and clinical interpretation, targeting the health workforce, researchers and policy-makers, to ensure and to foster the safe, effective and equitable application of precision medicine;

(7) to encourage and promote equitable access to precision medicine services and technologies by investing in sustainable financing models and implementing pooled procurement, thereby supporting affordability and inclusivity;

(8) to foster research collaboration and innovation in precision medicine that reflects the diversity of global populations and sex-disaggregated data and that addresses national and regional health priorities, including neglected and rare diseases;

(9) to strengthen existing or establish new national centres and institutions for genomics research, as needed, with a view to enhancing national capacity and accelerating the ethical application of genomic advances in relation to national health problems;

(10) to empower individuals, families and communities through health literacy, awareness and participatory engagement, recognizing their essential role in the co-creation and implementation of precision medicine policies and programmes and fostering inclusivity, transparency and public trust, in a way that no one is left behind;

(11) to establish or maintain evidence-based mechanisms for the assessment and prioritization of precision medicine technologies to evaluate their clinical effectiveness, cost-effectiveness, safety and quality;

(12) to strengthen collaboration among governments, academic and research institutions, civil society, the private sector and other relevant stakeholders to promote the exchange of precision medicine technologies, knowledge-sharing, resource mobilization and capacity-building, respecting international rules and national rules in line therewith, to advance equitable, inclusive and sustainable innovation in precision medicine;

(13) to promote harmonization of data standards and interoperability frameworks, aligned with WHO's global strategy on digital health 2020–2027 and international governance, ethics and regulatory guidelines on artificial intelligence, and drawing on existing initiatives;

2. REQUESTS the Director-General:

(1) to review and map existing WHO guidance and recommendations relevant to precision medicine, and if necessary, consider the development of a global strategy on precision medicine in consultation with Member States and relevant stakeholders, in line with the Framework of Engagement with Non-State Actors, as applicable, and in line with the Fourteenth General Programme of Work, 2025–2028 and prioritization process, to set out guiding principles, ethical and technical standards, and a road map for equitable, sustainable and context-appropriate implementation of precision medicine within universal health coverage frameworks;

(2) to provide technical and normative support to Member States, particularly developing countries, upon request, in developing policies, governance mechanisms, regulatory frameworks and capacity-building initiatives that enable the safe, effective and equitable application of precision medicine, drawing on existing WHO guidance, tools and expertise, including through further strengthening and coordinating existing WHO institutional capacity in genomics, data science, bioinformatics and digital health;

(3) to develop, upon the request of Member States, and in consultation with Member States and relevant stakeholders, in line with the Framework of Engagement with Non State Actors, as applicable, a country maturity model consisting of a structured framework with progressive stages and measurable indicators, for the differentiated integration of precision medicine interventions, enabling Member States and institutions to assess current capacity, identify priorities, track progress and guide phased implementation, in line with national contexts and health system readiness;

(4) to facilitate regional and global platforms for knowledge exchange, best practices and innovation in precision medicine, taking into consideration data privacy and security at the aggregated level, as well as countries' contexts, including but not limited to the development of population-diverse national genomic reference databases, ensuring equitable representation, transparency and benefit-sharing;

(5) to facilitate, as appropriate, the establishment of new or the strengthening of existing regional networks and capacity-building hubs in genomics and related fields, paying particular attention to the health needs of developing countries, building on and supporting existing regional initiatives;

(6) to strengthen global, regional and national collaboration with relevant partners and stakeholders, academic and research institutions, and civil society, in line with the

Framework of Engagement with Non-State Actors, as applicable, to mobilize resources, foster research and innovation and promote equitable access to digital tools and technologies appropriate to precision medicine, respecting international rules;

(7) to report on the implementation of this resolution to the Eightieth and Eighty-second World Health Assemblies in 2027 and 2029, respectively, on the progress achieved;

(8) to submit, pursuant to paragraph 2(1), the global strategy on precision medicine for consideration by the Executive Board at its 164th session, with a view to its submission for adoption by the Eighty-second World Health Assembly in 2029.

(Fourth meeting, 3 February 2026)

EB158.R3 Strengthening equitable access to diagnostic imaging through teleradiology²⁵

The Executive Board,

Having considered the reports by the Director-General on universal health coverage,

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

The Seventy-ninth World Health Assembly,

Having considered the report by the Director-General;

Recalling resolution WHA71.7 (2018) on digital health, resolution WHA76.5 (2023) on strengthening diagnostics capacity, and the WHO global strategy on digital health 2020–2025,²⁶ which collectively emphasize the critical role of digital technologies and diagnostics in achieving universal health coverage and the health-related Sustainable Development Goals;

Recognizing that diagnostic imaging, including radiology, is an essential component of healthcare, vital for the timely detection, diagnosis, management, treatment planning, and monitoring of communicable diseases, noncommunicable diseases, trauma, and maternal and child health conditions and other medical conditions, particularly in developing countries, including but not limited to small island developing States and remote and underserved areas;

Acknowledging that access to radiology services remains limited in and within many countries particularly developing countries and remote or rural areas, and noting with concern the shortage of trained and certified radiologists and other imaging professionals, which contributes to delayed or missed diagnoses and poorer health outcomes and preventable deaths;

²⁵ See Annex 5 for the financial and administrative implications for the Secretariat of this resolution.

²⁶ [Global strategy on digital health 2020–2025](#). Geneva: World Health Organization; 2021 (accessed 2 February 2026).

Further noting that the absence of trained personnel to interpret the images, or weak referral systems, leads to suboptimal utilization of the equipment and may limit the effective use of existing imaging capacity;

Recognizing that teleradiology, the use of telecommunications technology to transmit and interpret medical images remotely, can offer a scalable, cost-effective and practical solution to help to bridge the human resource gap and extend the reach of expert diagnostic services to underserved populations;^{27,28}

Acknowledging that teleradiology, the secure and privacy preserving digital transmission, and remote interpretation of diagnostic images, can expand access to imaging, optimize use of limited expertise and improve quality of care, provided that the laws, regulations, standards and ethical rules governing this medical practice are respected;

Noting that, when appropriately implemented, teleradiology can contribute to the achievement of universal health coverage by increasing efficiency, supporting continuous education and strengthening preparedness and response capacities;

Recognizing that, for the integration of artificial intelligence and digital health platforms, including teleradiology, into radiology services, it is necessary to ensure that these tools are developed, validated, safely deployed and governed ethically for performance, and implemented under clinical oversight, while ensuring inclusive and equitable access, in order to optimize the use of limited expert resources, improve the quality of interpretation, and ensure timely diagnosis across diverse settings;

Concerned that uncoordinated adoption, absence of national policy frameworks, weak data protection and fragmented infrastructure may lead to unsafe deployment of teleradiology services;

Considering that the effective and ethical adoption of teleradiology, where appropriate, requires robust national policy frameworks, regulatory standards, interoperability guidelines and secure data protection mechanisms to ensure patient complete information, patient consent, patient safety and confidentiality;

Recognizing the importance of international solidarity, cooperation and investment to facilitate the sharing of expertise and best practices in teleradiology, particularly through partnerships among countries, while respecting patient privacy and respecting national data sovereignty;

Conscious of the need to integrate teleradiology into national and regional health and digital strategies as a core component of strengthening health systems and accelerating progress towards achieving universal health coverage and health equity,

²⁷ Jing AB, Garg N, Zhang J, Brown JJ. AI solutions to the radiology workforce shortage. *Npj Health Systems*. 2025;2(1): 20. doi: 10.1038/s44401-025-00023-6.

²⁸ Nigatu AM, Yilma TM, Gezie LD, Gebreworld Y, Gullslett MK, Mengiste SA, et al. Barriers and facilitators experienced during the implementation of web-based teleradiology system in public hospitals of the northwest Ethiopia: An interpretive description study. *International Journal of Telemedicine Applications*. 2024:5578056. doi: 10.1155/2024/5578056.

1. URGES Member States, taking into account national and regional context and capacities, and priorities:

- (1) to integrate teleradiology within national health, digital health and diagnostic strategies, aligned with universal health coverage objectives;
- (2) to develop or strengthen national policies, standards and regulatory frameworks for safe, ethical and effective teleradiology, including data governance, patient privacy, information and cross-border consultations;
- (3) to explore sustainable finance options, where appropriate, for infrastructure and expand the use of digital platforms to enable reliable, secure and sustainable image acquisition, transmission and reporting, in order to enable the reliable and secure transmission and storage of medical images;
- (4) to strengthen workforce capacity through education, training and mentorship programmes for all professionals involved, in partnership with academic and professional institutions;
- (5) to promote the integration of teleradiology systems with national health information systems;
- (6) to promote regional and international cooperation and knowledge-sharing to maximize the impact of limited radiology expertise and facilitate the exchange of best practices and technical knowledge with consideration of developing countries, including but not limited to small island developing States;
- (7) to give due consideration to equity, including the needs of underserved, rural and remote areas and including vulnerable populations, in line with national priorities and existing health system arrangements;
- (8) to support the safe trustworthy, accurate, robust and ethical use of artificial intelligence and decision-support tools in teleradiology workflows, in an inclusive and equitable manner with appropriate validation, transparency and human oversight according to appropriate regulatory protocols;

2. REQUESTS the Director-General:

- (1) to develop and disseminate normative guidance, standards and technical tools that enable safe, ethical, and effective teleradiology implementation, including interoperability and data protection;
- (2) to provide technical assistance to Member States, especially in developing countries, to support policy development, capacity-building and infrastructure planning;
- (3) to facilitate global and regional collaboration and partnerships, for training, research, and knowledge exchange in radiology and digital health;
- (4) to improve data collection on global teleradiology capacity through existing WHO instruments;

(5) to promote regional cooperation, and knowledge exchange, to support training, quality assurance and mutual assistance among Member States;

(6) to implement operative paragraphs (1) to (5) above in accordance with the Fourteenth General Programme of Work, 2025–2028, and within available resources, including through future resource mobilization efforts, and in the context of the implementation of relevant resolutions and strategies, including resolution WHA76.5 on strengthening diagnostics capacity, resolution WHA78.13 (2025) on strengthening medical imaging capacity, and the global strategy on digital health 2020–2025 (extended to 2027)²⁹ and its successor;

(7) to report on progress in implementing this resolution, using existing reporting streams, to the Eighty-third World Health Assembly in 2030.

(Fourth meeting, 3 February 2026)

EB158.R4 Reducing the burden of stroke: strengthening prevention, acute care, rehabilitation and health system readiness³⁰

The Executive Board,

Having considered the reports by the Director-General on universal health coverage,

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

The Seventy-ninth World Health Assembly,

Having considered the report by the Director-General;

Recalling the commitment made by Heads of State and Government to reduce premature mortality from noncommunicable diseases by one third by 2030, and the need to accelerate progress toward these goals, as appropriate, as set out in Sustainable Development Goal 3.4, and the extension of WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2020 to 2030,³¹ the intersectoral global action plan on epilepsy and other neurological disorders 2022–2031 (decision WHA75(11) (2022)),³² and the global strategy on digital health 2020–2025,³³

Having considered the reports by the Director-General on noncommunicable diseases, health systems resilience and universal health coverage,³⁴

²⁹ See decision WHA78(22) (2025).

³⁰ See Annex 5 for the financial and administrative implications for the Secretariat of this resolution.

³¹ [Global action plan for the prevention and control of noncommunicable diseases 2013–2020](#). Geneva: World Health Organization; 2013 (accessed 2 February 2026).

³² [Intersectoral global action plan on epilepsy and other neurological disorders 2022–2031](#). Geneva: World Health Organization; 2022 (accessed 2 February 2026).

³³ [Global strategy on digital health 2020–2025](#). Geneva: World Health Organization; 2021 (accessed 2 February 2026).

³⁴ See documents EB158/6, EB158/26 and EB158/11.

Recognizing that cardiovascular diseases, which can lead to stroke, are the leading cause of noncommunicable diseases mortality, accounting for approximately 19 million deaths annually,³⁵ and that stroke is the second-leading cause of death globally and the third-leading cause of disability,³⁶ are a principal contributor to disability worldwide;

Noting with deep concern that the burden of stroke has grown rapidly in low- and middle-income countries, which account for approximately 87% of stroke deaths, and that the number of new cases and deaths from stroke increased by 70% and 44%, respectively, between 1990 and 2021;³⁷

Noting with deep concern that stroke remains a leading cause of death and a major cause of disability, with differences in distribution of causes and risk factors across the life course, including for women during pregnancy and the post-partum period and when using oral contraception or experiencing migraines, and further noting that women experience poorer functional recovery and higher mortality than men owing to factors such as age, severity of stroke, pre-stroke dependency and depression, while men experience a greater burden of stroke at younger ages, including premature mortality and long-term disability, therefore underscoring an approach that identifies and addresses gender inequalities across the life course, among other factors, in stroke research, prevention and treatment;

Acknowledging that the high burden in developing countries is exacerbated by a lack of stroke-ready care, limited access to affordable essential medicines, inadequate rehabilitation services and a high prevalence of uncontrolled risk factors and medical conditions, such as but not limited to hypertension, diabetes, obesity, dyslipidaemia, physical inactivity, tobacco use, harmful use of alcohol, illicit drug use and air pollution, as well as undiagnosed or poorly managed atrial fibrillation and other cardiovascular diseases;

Acknowledging that stroke has substantial social and economic costs, including direct healthcare expenditures and indirect costs owing to loss of productivity and long-term care needs that often result in a reliance on informal caregiving, thereby undermining development and household financial security by increasing out-of-pocket expenditures and long-term dependency;³⁸

Concerned that the health systems of several Member States, particularly in developing countries and in resource-constrained regions, lack comprehensive, coordinated stroke services ranging from primary prevention and stroke-ready emergency systems to timely access to imaging, reperfusion therapies and essential medicines, through to rehabilitation, community support and long-term follow-up care;

Noting the evidence of critical gaps in certain countries across the stroke continuum, such as low detection and treatment rates for hypertension and other risk factors; low public

³⁵ [Global Burden of Disease 2023](#). Seattle, WA: Institute for Health Metrics and Evaluation; 2025. (accessed 25 September 2025).

³⁶ Feigin VL, Brainin M, Norrving B, Martins SO, Pandian J, Lindsay P, et al. World Stroke Organization: Global Stroke Fact Sheet 2025. *International Journal of Stroke*. 2025;20(2):132–144. doi:10.1177/17474930241308142.

³⁷ GBD 2021 Stroke Risk Factor Collaborators. Global, regional, and national burden of stroke and its risk factors, 1990–2021: a systematic analysis for the Global Burden of Disease Study 2021. *Lancet Neurology*. 2024;23:973–1003. doi:10.1016/S1474-4422(24)00369-7.

³⁸ [Stroke. Fact sheet](#). Geneva: World Health Organization; 2025 (accessed 2 February 2026).

awareness of stroke signs and insufficient prehospital emergency care; limited access to essential neuroimaging; limited availability of stroke units, thrombolysis/thrombectomy and neurosurgery services; suboptimal secondary prevention; inadequate rehabilitation and long-term support capacity; and lack or need for strengthening of national stroke registries and data to guide policy; and shortages of trained health workers across primary, emergency, acute and rehabilitative care pathways, as well as significant geographical disparities in access;

Conscious of the need for dedicated global leadership and coordinated action requiring the strengthening of WHO's technical capacity for noncommunicable diseases and the establishment of multisectoral national stroke units within Member States³⁹ to close the existing gaps and inequalities in the stroke care pathway, thereby reducing premature mortality and disability and strengthening health system resilience in line with Sustainable Development Goal 3.4;

Emphasizing that effective stroke care requires action across the life course and across health system levels, including strengthened primary prevention, and that many evidence-based and cost-effective interventions exist to reduce stroke incidence and improve outcomes, including hypertension control; diabetes and dyslipidaemia management; screening for atrial fibrillation; salt reduction; promotion of healthy diets and physical activity; effective tobacco cessation; adoption of alcohol strategies, interventions and policies in line with the global alcohol action plan 2022–2030⁴⁰ to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority; responses to illicit drug use; reduction of air pollution; as well as timely and coordinated emergency medical services; access to organized stroke unit care and reperfusion therapies such as thrombolysis and mechanical thrombectomy; availability of anticoagulation for atrial fibrillation; and access to long-term rehabilitation, community reintegration and social support, while noting with concern that the adoption, scale-up and equitable implementation of these interventions remain insufficient in many countries;

Emphasizing the critical need to continue to integrate stroke prevention, control and management into national cardiovascular disease and neurological disorders strategies and universal health coverage plans to foster equitable access to the full spectrum of care, particularly persons in vulnerable situations, and to reduce health inequalities;

Acknowledging the central role of health system strengthening, digital health, diagnostics including imaging, workforce training and rehabilitation services integration in achieving measurable reductions in stroke mortality and disability;

Noting the absence of a focused WHO resolution addressing stroke comprehensively that takes into account prevention, acute care, rehabilitation and system readiness and that recognizes the specific time-dependent nature requiring coordinated emergency care, and cognizant of the opportunity to stimulate coordinated national and global action;

Affirming the importance of standardized national stroke registries and surveillance systems to accurately monitor the incidence, prevalence, mortality, disability, quality of care

³⁹ See document A75/2022/REC/1, Annex 8: Implementation roadmap 2023–2030 for the global action plan for the prevention and control of noncommunicable diseases 2013–2030.

⁴⁰ [Global alcohol action plan 2022–2030](#). Geneva: World Health Organization; 2024 (accessed 2 February 2026).

and patient-reported outcomes, which is essential for evidence-based policy-making and resource allocation,

1. URGES Member States,⁴¹ in accordance with national contexts and capacities, and where appropriate:

- (1) to include stroke as one of the major public health concerns within national cardiovascular disease and neurological disorders strategies and universal health coverage planning, with dedicated objectives across the prevention, acute care and rehabilitation continuum;
- (2) to implement and strengthen population-level prevention measures as well as measures to reduce health inequalities proven to reduce stroke risk, including but not limited to implementation of large-scale detection and control programmes for hypertension, diabetes, obesity and dyslipidaemia; adoption of legislation, regulation, policies and actions, as appropriate, to reduce excessive levels of saturated fats, free sugars and sodium in food products; support for effective tobacco cessation; adoption of alcohol strategies, interventions and policies in line with the global alcohol action plan 2022–2030 to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority; promotion of healthy diets and physical activity and implementation of health literacy and school-based education programmes to foster healthy habits among children and adolescents; and actions to reduce household and ambient air pollution, in line with national circumstances;
- (3) to foster primary care readiness by developing and implementing national stroke care pathways for stroke prevention by scaling up and conducting systematic screening for risk factors, including hypertension, hyperglycaemia/diabetes, dyslipidaemia and atrial fibrillation; fostering continuous supply and affordable access to essential medicines for blood pressure, glycaemic and lipid control and antiplatelet and anticoagulant therapies as appropriate; integrating counselling for lifestyle risk modification into routine primary care contacts by using evidence-based and effective methods; and establishing global coverage targets on hypertension prevention and control;
- (4) to strengthen emergency care systems so that patients with suspected acute stroke receive timely triage, rapid transport and access to imaging and reperfusion therapies where clinically indicated by:
 - (a) defining and designating stroke-ready levels of emergency care facilities with minimum capability standards in terms of imaging, laboratory access, trained staff and capacity for thrombolysis;
 - (b) establishing prehospital stroke recognition and triage protocols, public awareness campaigns for early presentation and streamlined referral pathways between primary care, emergency services and stroke units;

⁴¹ And, where applicable, regional economic integration organizations.

- (c) raising awareness of health personnel in emergency care systems about the differences in stroke symptoms among women and men to ensure equitable care for all;
- (5) to expand access to timely diagnostic imaging, including computed tomography and magnetic resonance imaging or validated alternatives, where appropriate, and essential laboratory tests required for acute stroke management;
- (6) to scale up evidence-based acute interventions, including intravenous thrombolysis where indicated and systems to enable endovascular thrombectomy in referral centres, as well as the implementation of standardized care bundles for acute intracerebral haemorrhage, including rapid blood pressure control and coagulopathy reversal, and specialized management pathways for subarachnoid haemorrhage, ensuring access to neurosurgical care in referral centres with protocols for timely transfer and interfacility cooperation;
- (7) to invest in multidisciplinary stroke units and rehabilitation, ensuring inpatient stroke units with multidisciplinary teams inter alia, physiotherapy, occupational therapy, speech and language therapy, nursing and medical care, early supported discharge models, palliative and end-of-life care, where appropriate, and community-based rehabilitation and social support for survivors to optimize functional recovery and reintegration;
- (8) to facilitate the development and maintenance of national stroke registries and surveillance systems to collect standardized data, including information on incidence and data on key indicators of stroke disaggregated by sex, mortality, risk factors, service availability, reperfusion therapy rates, time-to-treatment, rehabilitation access, functional outcomes, patient-reported outcomes and long-term quality of life, to guide policy, monitor progress and enable quality improvement;
- (9) to strengthen the health workforce by incorporating stroke prevention, acute care and rehabilitation into pre-service curricula and continuing professional development for physicians, nurses, allied health professionals and community health workers; support task-sharing, where appropriate, with clear competency frameworks and clinical governance; and implement retention and incentive strategies for underserved areas;
- (10) to promote equitable and affordable access by targeting investments and service expansion to underserved, rural and low-income populations, ensuring financial protection mechanisms to reduce out-of-pocket costs for stroke care and rehabilitation;
- (11) to adopt and implement clinical protocols and quality-assurance mechanisms, including national clinical guidelines for stroke prevention and care, audit and peer-review systems, performance indicators and continuous quality improvement processes across the stroke care pathway;
- (12) to foster regional and intercountry collaboration in respect of shared training, referral networks, pooled procurement for essential medicines and consumables such as telemedicine/teleradiology arrangements, and regional centres of excellence that can provide mentorship and surge capacity during emergencies;

(13) to explore and mobilize, as appropriate, sustainable financing for stroke prevention and care, including domestic and international resources, innovative pooled financing mechanisms, alignment with relevant donor programmes and integration of stroke services into universal health coverage benefit packages to foster long-term affordability and scalability;

(14) to engage communities and civil society, including stroke survivor organizations and caregivers, in designing and monitoring policies and services, supporting public awareness and secondary prevention adherence, and reducing stigma associated with disability;

(15) to integrate digital health solutions including, inter alia, registries, telemedicine, teleradiology, clinical decision support and mobile health for follow-up and rehabilitation, in a manner that ensures interoperability, data protection, inclusion and alignment with national digital health strategies;

(16) to build workforce capacity by training health professionals across the continuum of care, from primary care providers to emergency personnel, neurologists and rehabilitation specialists, in evidence-based stroke management;

2. REQUESTS the Director-General:

(1) to develop normative guidance and technical tools for Member States on comprehensive stroke prevention, acute care readiness, rehabilitation and long-term support that focus on advancing health equity, rights and gender equality;

(2) to integrate stroke into existing global cardiovascular and neurological disorders strategies that can be adapted according to national context;

(3) to support Member States, especially developing countries, in strengthening their capacity for stroke system models adapted to resource levels;

(4) to facilitate global stroke monitoring and reporting, harmonized with existing WHO cardiovascular disease, neurological disorders and universal health coverage monitoring systems;

(5) to promote research and evidence generation on context-appropriate, cost-effective interventions for stroke prevention, acute management and rehabilitation in developing countries;

(6) to support equitable access to essential medicines and identify priority lists for stroke prevention and acute care, including in respect of medicines for blood pressure and dyslipidaemia management, antiplatelets, anticoagulants, thrombolytic agents and basic imaging capability, advising on procurement strategies and supply-chain resilience, and exploring pooled procurement mechanisms where feasible;

(7) to encourage regional cooperation and technical partnerships, including, where appropriate, the establishment or designation of regional centres of excellence for stroke care that can provide training, quality assurance and surge capacity support;

(8) to report on progress in the implementation of this resolution to the World Health Assembly through the report submitted in response to decision

WHA72(11) (2019) on follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, which also covers the outcome of the fourth high-level meeting of the General Assembly on the prevention and control of non-communicable diseases and the promotion of mental health and well-being on progress made in addressing stroke as part of the global noncommunicable disease agenda and of the intersectoral global action plan on epilepsy and other neurological disorders 2022–2031;⁴²

3. ENCOURAGES relevant stakeholders, including intergovernmental organizations, philanthropic agencies, academic institutions, professional societies, civil society, private-sector partners and donors, to support Member States and, in line with the Framework of Engagement with Non-State Actors, and where applicable, WHO in implementing the actions provided for in this resolution, as appropriate.

(Fourth meeting, 3 February 2026)

EB158.R5 Advancing smart, efficient pharmacovigilance as an essential tool for robust, sustainable, resilient and responsive health systems, for everyone, everywhere⁴³

The Executive Board,

Having considered the reports by the Director-General on universal health coverage,

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

The Seventy-ninth World Health Assembly,

Having considered the report by the Director-General on universal health coverage;

Recalling resolution WHA16.36 (1963) urging the systematic reporting of serious adverse drug reactions and the establishment of international drug safety monitoring, including the WHO Programme for International Drug Monitoring and the designation of the Uppsala Monitoring Centre as the WHO Collaborating Centre for International Drug Monitoring;

Noting resolutions WHA60.20 (2007), WHA61.21 (2008), WHA62.16 (2009), WHA63.12 (2010), WHA65.17 (2012), WHA65.19 (2012), WHA66.22 (2013), WHA67.20 (2014), WHA67.21 (2014), WHA67.22 (2014), WHA68.7 (2015), WHA71.8 (2018) and WHA72.8 (2019), all of which encompass aspects of the need to promote access to quality, safe, effective and affordable medicines and other health technologies⁴⁴ as appropriate;

⁴² See decision WHA75(11) (2022).

⁴³ See Annex 5 for the financial and administrative implications for the Secretariat of this resolution.

⁴⁴ Medicines and other health technologies includes pharmaceuticals, vaccines, biopharmaceuticals and medical devices.

Recalling resolution WHA61.21, decision WHA71(9) (2018) and document A71/12, insofar as they address the role of technology transfer and local production of medicines and other health technologies on improving access as appropriate;

Recalling resolution WHA73.1 (2020) on a comprehensive and coordinated response to the coronavirus disease (COVID-19) pandemic, which calls for intensified international cooperation and solidarity to contain, mitigate and overcome the pandemic and its consequences through responses that are people-centred and address gender inequalities;

Reaffirming the commitment to Sustainable Development Goal 3.8 to achieve universal health coverage, including access to safe, effective, quality and affordable essential medicines and vaccines for all;

Acknowledging the lessons from the coronavirus disease (COVID-19) pandemic and other public health emergencies, which highlighted the essential role of functional pharmacovigilance systems for the rapid detection and management of safety signals associated with novel health products, including vaccines and medical devices, and, equally, of timely, transparent and accurate risk communication as a way to inform the public, support informed decision-making and reinforce confidence in public health interventions;

Recognizing that pharmacovigilance data suggest distinct safety profiles across sexes and ages, where differences in reporting, outcomes and vulnerability to adverse events may exist;^{45,46}

Recognizing also that despite global progress, significant inequities persist in pharmacovigilance capacity, with many developing countries facing capacity and resource constraints and contributing a disproportionately small share of global safety data, resulting in populations being unequally protected against adverse events and limiting the quality and completeness of global safety data;

Acknowledging the emergence of a multitude of parallel safety monitoring systems in countries across various disease treatment programmes that often operate in silos, and may lead to inefficient use of resources and scattered data;

Recognizing the critical role of national and regional regulatory authorities and global institutions, their collaboration, the need for comprehensive and integrated pharmacovigilance systems that enable robust, timely evidence-based, benefit-risk assessment of medicines and other health technologies;

Recognizing also that collaboration between national and regional authorities and global institutions is also key to addressing capacity-building gaps;

⁴⁵ Watson S, Caster O, Rochon PA, den Ruijter H. Reported adverse drug reactions in women and men: aggregated evidence from globally collected individual case reports during half a century. *eClinicalmedicine*. 2019 Dec;17:100188. doi: 10.1016/j.eclinm.2019.10.001.

⁴⁶ Aurich B, Apele-Freimane D, Banaschewski T, Chouchana L, Day S, Kaguelidou F, et al. c4c: Paediatric pharmacovigilance: Methodological considerations in research and development of medicines for children – A c4c expert group white paper. *British Journal of Clinical Pharmacology*. 2021 Oct 26;88(12):4997-5016. doi: 10.1111/bcp.15119.

Recognizing further that good vigilance practices, including in local production, are essential to foster access to safe, effective and quality assured medicines and other health technologies in a country;

Noting the transformative potential of digital technologies, real-world data and artificial intelligence to enhance safety surveillance, signal detection and regulatory decision-making;

Recognizing the challenges related to the principles of data governance, privacy, interoperability, access to data,^{47,48} and acceptance by regulators;

Stressing that smart, risk-based, integrated and collaborative pharmacovigilance strategies can maximize the impact of limited public health resources, enhance the timeliness of safety signal detection, avoid duplication, and foster reliance and work-sharing and harmonized decision-making among Member States and regions;

Acknowledging that misinformation and disinformation about the safety of medicines, vaccines and medical devices, and more broadly about science, can seriously undermine public confidence and trust in these life-saving products and public health programmes and cause harm;

Affirming that strengthening pharmacovigilance contributes to public trust in health systems and immunization programmes,^{49,50} improves patient safety and is an essential component for achievement of the goals of universal health coverage and preparedness for future health emergencies, including the uptake and impact of norms and standards on smart pharmacovigilance; additionally, it has a significant economic impact, as it optimizes resource allocation and reduces the broader costs associated with adverse events;

Noting that Member States continue to access and benefit from all the resources and services that are already offered by WHO through the Uppsala Monitoring Centre as the WHO Collaborating Centre for International Drug Monitoring,

1. URGES Member States,⁵¹ in accordance with their national context and priorities:

(1) to drive the integration of vigilance systems in order to optimize the use of vigilance data and evidence, for a more comprehensive regulation of medicines and other health technologies and patient care;

(2) to strengthen national pharmacovigilance systems including patient/consumer reporting systems so that patients and caregivers can easily report adverse events to

⁴⁷ [VigiBase data access conditions](#). Geneva: World Health Organization; 2025. (accessed 29 January 2026).

⁴⁸ [VigiAccess: frequently asked questions](#). Geneva: World Health Organization; 2026. (accessed 29 January 2026).

⁴⁹ Iessa N, Sarinic VM, Ghazaryan L, Romanova N, Alemu A, Rungapiromnan W, et al. Smart Safety Surveillance (3S): Multi-Country Experience of Implementing the 3S Concepts and Principles. *Drug Safety*. 2021 Oct;44(10):1085–98. doi: 10.1007/s40264-021-01100-z.

⁵⁰ [Unmasking safety signals during a pandemic](#). Technical meeting report. Geneva: World Health Organization; 2022 (accessed 29 January 2026).

⁵¹ And, where applicable, regional economic integration organizations.

health authorities/institutions and to support education and awareness efforts on how to identify and report such events;

(3) to strengthen and modernize national pharmacovigilance systems as an integral part of regulatory systems where applicable, including where appropriate through adequate governance, domestic and international financing, and human resource capacity (in addition to the resources that are provided by WHO to Member States, free of cost, through the Uppsala Monitoring Centre);

(4) to consider or strengthen the application of safety and vigilance principles beyond medicines and vaccines to include other relevant health products;

(5) to adopt evidence-based, smart and effective approaches to pharmacovigilance, addressing the most significant risks and prioritizing high-impact activities and products, and to participate where appropriate in regional or global work and reliance mechanisms to optimize resource use;

(6) to develop or strengthen relevant legal and regulatory frameworks, guidelines and manuals to support, where appropriate, good pharmacovigilance practices as an essential responsibility of manufacturers, including in local production, for quality assured essential medicines;

(7) to leverage real-world data, digital platforms and innovative tools, including artificial intelligence and machine learning, in a safe, transparent and ethical manner to improve safety signal detection and response, while also maintaining public trust;

(8) to promote the integration of sex- and age-related safety considerations throughout the development, regulation and use of medicines and to strengthen pharmacovigilance systems that routinely collect, analyse and use sex- and age-disaggregated data on adverse events for diverse population groups;

(9) to integrate pharmacovigilance within relevant strategies that advance universal health coverage, ensuring patient safety monitoring across all levels of care;

(10) to integrate pharmacovigilance training in teaching institutions and strengthen regulatory capacity-building and workforce training in pharmacovigilance;

(11) to collaborate with local, regional and global stakeholders, including public health programmes, academic institutions, the private sector where appropriate, and patients' organizations, to strengthen pharmacovigilance and knowledge sharing;

(12) to establish or further utilize, where appropriate, pharmacovigilance coordination platforms with partners and stakeholders at the national, regional and global levels for resource optimization and timely decision-making;

2. REQUESTS the Director-General:

(1) to continue to update the existing or, if necessary, to develop global normative guidance and technical tools in consultation with Member States to support "smart pharmacovigilance", taking into consideration real world evidence and the ethical use of artificial intelligence for pharmacovigilance purposes and align with existing initiatives in this area;

(2) to consolidate performance metrics for pharmacovigilance systems and provide technical support to Member States, upon their request, in assessing and improving

their pharmacovigilance systems, including the uptake and impact of norms and standards on smart pharmacovigilance;

(3) to continue enhancing international collaboration and information sharing, reliance and work-sharing for effective pharmacovigilance among Member States and regions, and continue to take measures to strengthen health literacy on pharmacovigilance to counter disinformation and misinformation, including by facilitating access to evidence-based and science-based information;

(4) to support data quality, interoperability and equitable participation of all Member States including developing countries, building on global databases⁵² while respecting data sovereignty and data security;

(5) to promote capacity development through training programmes for workers in the healthcare and related sectors, including knowledge exchange, and the dissemination of best practices in pharmacovigilance system design and operation;

(6) to report back to the Eighty-first, Eighty-third and Eighty-fifth World Health Assemblies in 2028, 2030 and 2032, respectively, on progress in implementing this resolution and on the state of global pharmacovigilance systems, including their contribution to universal health coverage and health emergency preparedness.

(Fourth meeting, 3 February 2026)

EB158.R6 Health conditions in the occupied Palestinian territory, including east Jerusalem⁵³

The Executive Board,

Having considered the report by the Director-General,⁵⁴

RECOMMENDS that the Seventy-ninth World Health Assembly adopt, *mutatis mutandis*, the resolution EBSS7.R1 (2023) as is, other than the following textual revisions:

(1) in operative paragraph 5(a) to replace the phrase “submit recommendations in this regard to the 154th session of the Executive Board and to the fourth meeting of the Standing Committee on Health Emergency Prevention, Preparedness and Response, and to the Seventy-seventh World Health Assembly” with “submit recommendations in this regard to the 160th session of the Executive Board and to the eighth meeting of the Standing Committee on Health Emergency Prevention, Preparedness and Response, and to the Eightieth World Health Assembly”;

(2) in operative paragraph 5(b) to replace the phrase “prior to the Seventy-seventh World Health Assembly” with “prior to the Eightieth World Health Assembly”.

(Seventeenth meeting, 5 February 2026)

⁵² [The global medicines safety database](#) (accessed 30 January 2026).

⁵³ See Annex 5 for the financial and administrative implications for the Secretariat of this resolution.

⁵⁴ Document EB158/25.

EB158.R7 Confirmation of amendments to the Staff Rules: remuneration of staff in the professional and higher categories⁵⁵

The Executive Board,

Having considered the report by the Director-General,⁵⁶ and having also considered the report of the Programme, Budget and Administration Committee of the Executive Board,⁵⁷

CONFIRMS, in accordance with Staff Regulation 12.2, the amendments to the Staff Rules that have been made by the Director-General with effect from 1 January 2026 concerning the remuneration of staff in the professional and higher categories.⁵⁸

(Tenth meeting, 6 February 2026)

EB158.R8 Salaries of staff in ungraded positions and of the Director-General

The Executive Board,

Having considered the report on amendments to the Staff Regulations and Staff Rules,⁵⁶ and having also considered the report of the Programme, Budget and Administration Committee of the Executive Board,⁵⁷

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

The Seventy-ninth World Health Assembly,

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

1. ESTABLISHES the salaries of Assistant Directors-General and Regional Directors⁵⁹ at US\$ 217 448 gross per annum, with a corresponding net salary of US\$ 159 016;
2. ESTABLISHES the salary of the Deputy Director-General⁶⁰ at US\$ 239 200 gross per annum, with a corresponding net salary of US\$ 173 372;
3. ESTABLISHES the salary of the Director-General at US\$ 298 001 gross per annum, with a corresponding net salary of US\$ 222 101;
4. DECIDES that these adjustments in remuneration shall take effect from 1 January 2026.

(Tenth meeting, 6 February 2026)

⁵⁵ See Annex 5 for the financial and administrative implications for the Secretariat of this resolution.

⁵⁶ Document EB158/53.

⁵⁷ Document EB158/4.

⁵⁸ See Annex 1.

⁵⁹ Salary category UG1.

⁶⁰ Salary category UG2.

Decisions

EB158(1) Follow-up to the political declaration of the fourth high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases and the promotion of mental health and well-being¹

The Executive Board, having considered the report by the Director-General,²

Decided to recommend to the Seventy-ninth World Health Assembly the adoption of the following decision:

The Seventy-ninth World Health Assembly, having considered the report by the Director-General on the follow-up to the political declaration of the fourth high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases and the promotion of mental health and well-being,

Decided:

(1) to welcome the political declaration of the fourth high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases and the promotion of mental health and well-being and to request the Director-General to provide support to Member States for its implementation;

(2) to request the Director-General to report, through the Executive Board and until 2031, on the progress made in implementing the political declaration of the fourth high-level meeting, as part of the consolidated annual report on the progress achieved in the prevention and control of noncommunicable diseases and the promotion of mental health, pursuant to decisions WHA72(11) (2019) and WHA78(11) (2025).

(Third meeting, 3 February 2026)

EB158(2) Global action to advance health equity for people with haemophilia and other bleeding disorders¹

The Executive Board, having considered the report by the Director-General,²

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

The Seventy-ninth World Health Assembly,

¹ See Annex 5 for the financial and administrative implications for the Secretariat of this decision.

² Document EB158/6.

Having considered the report by the Director-General;

Noting that bleeding disorders, particularly inherited bleeding disorders, represent a group of disorders that are caused by absence or low levels of one or more proteins critical to the blood clotting process, and that they can affect both men and women;

Noting also that the most common types of bleeding disorders are haemophilia and von Willebrand disease, and that other clotting factor deficiencies include factor I (fibrinogen), factor II (prothrombin), factor V, a combined deficiency of factors V and VIII, factor VII, factor X, factor XI and factor XIII, in addition to inherited platelet disorders;

Recognizing the significant underdiagnosis of bleeding disorders, with only 34% of the expected number of people with haemophilia identified globally, and even greater disparities reported in diagnosis rates for people with von Willebrand disease, which has an estimated prevalence of 1 in 1000 individuals, and other bleeding disorders;

Recognizing also that women and girls with bleeding disorders face even greater challenges in accessing care, including biases in symptom assessment, longer diagnostic delays, underrepresentation in clinical trials and research programmes, societal stigma and challenges in accessing treatment, negatively impacting their physical health and quality of life, as women and girls with bleeding disorders may experience heavy menstrual bleeding, increased risk of anaemia, iron deficiency, and bleeding during pregnancy and childbirth; and greater challenges in accessing sexual and reproductive healthcare services, and therefore emphasizing the need to introduce an inclusive approach, including mainstreaming gender-sensitive and age-appropriate measures into the prevention and treatment of haemophilia and other bleeding disorders to adequately address the specific health risks and needs of women and men of all ages, giving particular attention to the impact of haemophilia and other bleeding disorders on women in all settings;

Recognizing further the shared clinical, diagnostic and health-system challenges faced by individuals living with inherited bleeding disorders and the need for integrated approaches that enhance equitable access to diagnosis, treatment and comprehensive care for all affected populations;

Acknowledging that the internationally recognized standard of care for haemophilia is prophylaxis and home treatment to prevent bleeding and reduce negative impacts on physical and mental health; whereas if left untreated recurrent bleeding could result in musculoskeletal complications and permanent joint damage, disability and premature mortality, as well as an increased burden on health systems with greater need for hospitalizations and management of complications resulting from delayed treatment;

Acknowledging also that despite significant innovations in treatment for haemophilia in recent years, over 70% of this population continues to have inadequate or no access to treatment globally, with disparities in diagnosis and care persisting across regions and resource settings, as well as by sex and type of bleeding disorder;

Recognizing that people with haemophilia and other bleeding disorders and their caregivers can experience a negative psychosocial impact, including isolation, stigmatization or discrimination, and adverse economic impact, including reduced access to education and employment, overall resulting in a broader societal cost, and recognizing that these impacts

are often intensified by the absence, limited scope or poor implementation of dedicated policies and social support;

Reaffirming the importance of WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2030 for an integrated approach to the prevention and control of noncommunicable diseases;

Recalling the United Nations Sustainable Development Goals, established pursuant to United Nations General Assembly resolution 66/288 (2012), specifically Goal 3 (Ensure healthy lives and promote well-being for all at all ages), target 3.4 (By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being) and target 3.8 (Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all), and Goal 5 (Achieve gender equality and empower all women and girls), in particular target 5.6 (Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences);

Recalling also the United Nations political declaration of the high-level meeting on universal health coverage (2019), and the political declaration of the high-level meeting on universal health coverage (2023), reiterating the commitment to ensure that no one is left behind;

Recalling further the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases (2018), specifically paragraph 28, which reaffirmed the right of everyone to the enjoyment of the highest attainable standard of physical and mental health across the life course, in respecting human rights obligations and addressing the specific health needs of children, women, older persons, persons with disabilities and others who are more vulnerable to noncommunicable diseases; paragraph 35, calling to strengthen health systems and reorient them towards the achievement of universal health coverage and improvement of health outcomes, and high-quality, integrated and people-centred primary and specialized health services for the prevention, screening and control of noncommunicable diseases; and paragraph 36, calling to promote increased access to affordable, safe, effective and quality medicines and diagnostics and other technologies;

Recalling United Nations General Assembly resolution 76/132 (2021) on addressing the challenges of persons living with a rare disease and their families, which paved the way for greater integration of rare diseases into the agenda and priorities of the United Nations system;

Recalling also resolution WHA63.12 (2010) on availability, safety and quality of blood products and the recent inclusion of several medicines for haemophilia and von Willebrand disease treatment on the WHO Model List of Essential Medicines, recognizing access to these essential medicines as a public health priority;

Recalling further resolution WHA76.5 (2023) on strengthening diagnostics capacity, which stressed the importance of diagnostic services for healthcare service delivery, ranging from prevention to treatment;

Recalling resolution WHA77.2 (2024) on social participation for universal health coverage, health and well-being, which called for regular and transparent social participation to ensure transparent decision-making for health across the policy cycle, at all levels of the system;

Recalling also resolution WHA78.11 (2025) on rare diseases: a global health priority for equity and inclusion, which requested the Director-General to develop a comprehensive 10-year global action plan on rare diseases, with measurable targets to guide progress towards equity, inclusion and access to care for all affected individuals;

Recognizing the role of WHO to demonstrate leadership and coordination of effective global action to advance health equity for people with haemophilia and other bleeding disorders, as part of WHO's larger public health impact and the strategic goal of providing health as outlined in the Fourteenth General Programme of Work, 2025–2028,

1. URGES Member States, taking into account national context and priorities and available resources and capacities:

- (1) to enhance, where relevant, within policies and responses related to national noncommunicable diseases, primary health, maternal and neonatal health, sexual and reproductive health and universal health coverage, the management of haemophilia and other inherited bleeding disorders, including early gender-sensitive and evidence-based diagnosis, equitable access to safe, effective and affordable treatment, multidisciplinary care and the development of evidence-based national clinical guidelines;
- (2) to strengthen health systems to increase capacity in identification and diagnosis, and clinical management of haemophilia and other bleeding disorders, by including relevant competencies in education and lifelong learning of health workers, by training, as appropriate and in particular, non-specialist healthcare providers in primary healthcare settings on basic management of bleeding disorders; ensuring timely referral to specialized haemophilia treatment centres; and, where feasible, by strengthening coordination among these specialized haemophilia treatment centres, already established in many Member States, with multidisciplinary teams providing comprehensive care services, with an efficient referral system in place;
- (3) to enhance equitable access to safe, effective and affordable medicines and to early treatment interventions, such as prophylaxis and home treatment programmes for people with haemophilia and other bleeding disorders, and to consider the inclusion of essential medicines for haemophilia and other bleeding disorders on national lists of essential medicines, as well as to promote predictable supply chains and explore financing mechanisms for these medicines, including factor concentrates, non-factor replacement therapies and other novel emerging therapies;
- (4) to strengthen national data collection systems to facilitate epidemiological, treatment and health outcomes surveillance, and monitoring and evaluation of existing haemophilia and other bleeding disorder programmes and responses, to better inform national policies and strategies and clinical practice;

- (5) to implement effective programmes that promote mental health and psychosocial support, including for persons living with haemophilia and other bleeding disorders, as well as policies and initiatives that enhance the well-being of their families;
- (6) to promote public awareness of and education about haemophilia and other bleeding disorders to foster greater understanding, promote global solidarity and reduce the misconceptions and stigmatization regarding bleeding disorders, including their impact on women and girls, that are widespread in certain regions;
- (7) to empower people living with bleeding disorders, local communities and organizations that represent them, through engagement and consultative mechanisms in care planning and service delivery, and in policy and legislation development, programme implementation, advocacy, research, and monitoring and evaluation;
- (8) to recognize World Haemophilia Day, celebrated on 17 April, as a day dedicated to haemophilia and all bleeding disorders, and to take appropriate measures within existing resources to continue to celebrate this day and raise awareness of bleeding disorders, in collaboration with local civil society actors and other relevant stakeholders;

2. REQUESTS the Director-General:

- (1) to assess and map existing WHO guidance and recommendations related to haemophilia and other bleeding disorders and develop, in collaboration with Member States, and in consultation with non-State actors, in line with the WHO Framework of Engagement with Non-State Actors, as applicable, and persons living with haemophilia and other bleeding disorders, recommendations for Member States on addressing gaps in strengthening the implementation of policies for haemophilia and other bleeding disorders, where relevant, within policies and responses related to national noncommunicable diseases, primary health, maternal and neonatal health and hygiene, menstrual health and universal health coverage, including early gender-sensitive and evidence-based diagnosis; and on enhancing equitable access to safe, effective and affordable treatment, and multidisciplinary care, taking into account adequate, predictable and sustainable domestic and international financing and national context and priorities, and to submit these recommendations to the Eighty-first World Health Assembly for its consideration in 2028, through the Executive Board at its 163rd session;
- (2) to recognize World Haemophilia Day, celebrated on 17 April, as a day dedicated to haemophilia and all bleeding disorders; to support relevant initiatives, in line with the global agenda for the prevention and control of noncommunicable diseases, by Member States and relevant stakeholders; and to consider taking appropriate measures to continue celebrating this day;
- (3) to report biennially on the implementation of the present resolution to the Health Assembly, as part of the global agenda for the prevention and control of noncommunicable diseases.

EB158(3) End TB Strategy³

The Executive Board, having considered the report by the Director-General,⁴

Decided to recommend to the Seventy-ninth World Health Assembly the adoption of the following decision:

The Seventy-ninth World Health Assembly, having considered the report on the End TB Strategy,

Decided to request the Director-General:

- (1) to develop a WHO post-2030 tuberculosis strategy, in consultation with Member States and relevant stakeholders, that will guide the Secretariat's support to Member States, is aligned with broader strategic frameworks, including primary healthcare, universal health coverage, and global health security, and takes into consideration the changing international public health architecture;
- (2) to submit to the Eighty-first World Health Assembly in 2028, through the Executive Board at its 162nd session, a WHO post-2030 tuberculosis strategy for its consideration;
- (3) to continue to report on the progress made towards ending tuberculosis to the Eighty-first and Eighty-third World Health Assemblies in 2028 and 2030, respectively, as requested in resolution WHA73.3 (2020), with the report to the Eighty-first World Health Assembly informing preparations for the third high-level meeting of the General Assembly on the fight against tuberculosis in 2028.

(Fourth meeting, 3 February 2026)

EB158(4) Draft global strategy for integrated emergency, critical and operative care, 2026–2035³

The Executive Board, having considered the report by the Director-General,⁵

Decided to recommend to the Seventy-ninth World Health Assembly the adoption of the following decision:

The Seventy-ninth World Health Assembly, having considered the draft global strategy for integrated emergency, critical and operative care, 2026–2035,

Decided:

- (1) to adopt the global strategy for integrated emergency, critical and operative care, 2026–2035;

³ See Annex 5 for the financial and administrative implications for the Secretariat of this decision.

⁴ Document EB158/10.

⁵ Document EB158/11.

- (2) to request the Director-General to report on progress made in the implementation of the global strategy to the Health Assembly as part of reporting on resolution WHA76.2 (2023) in 2027 and 2029, and subsequently in 2031 and 2035.

(Fourth meeting, 3 February 2026)

EB158(5) Increasing availability, ethical access and oversight of transplantation of human cells, tissues and organs⁶

The Executive Board, having considered the report by the Director-General,⁷

Decided to recommend to the Seventy-ninth World Health Assembly the adoption of the following decision:

The Seventy-ninth World Health Assembly, having considered the report by the Director-General on increasing availability, ethical access and oversight of transplantation of human cells, tissues and organs,

Decided:

- (1) to defer consideration of the proposed global strategy on donation and transplantation;
- (2) to request the Director-General to continue to develop the proposed global strategy and submit it for consideration by the Eightieth World Health Assembly in 2027, through the Executive Board at its 160th session.

(Fourth meeting, 3 February 2026)

EB158(6) Draft updated global action plan on antimicrobial resistance⁶

The Executive Board, having considered the report by the Director-General,⁸

Decided that informal consultations on the draft updated global action plan on antimicrobial resistance, and specifically on the subject of voluntary and mutually agreed technology transfer, will continue to be facilitated by the Secretariat in an inclusive and transparent manner prior to the Seventy-ninth World Health Assembly with a view to enabling the following draft decision to be submitted to Seventy-ninth World Health Assembly for adoption:

The Seventy-ninth World Health Assembly, having considered the report on the draft updated global action plan on antimicrobial resistance,

Decided:

- (1) to adopt the global action plan on antimicrobial resistance 2026–2036, as contained in the Annex;

⁶ See Annex 5 for the financial and administrative implications for the Secretariat of this decision.

⁷ Document EB158/12.

⁸ Document EB158/18.

(2) to request the Director-General to report on progress achieved in implementation of the updated global action plan on antimicrobial resistance, as part of consolidated biennial reports on antimicrobial resistance, to the Eightieth and Eighty-second World Health Assemblies in 2027 and 2029, respectively, as well as to the Eighty-fourth World Health Assembly in 2031.

(Fifth meeting, 4 February 2026)

EB158(7) WHO Global Code of Practice on the International Recruitment of Health Personnel⁹

The Executive Board, having considered the report by the Director-General,¹⁰

Decided:

- (1) to reiterate its support for the WHO Global Code of Practice on the International Recruitment of Health Personnel;
- (2) to recognize the final report of the Expert Advisory Group on the WHO Global Code of Practice on the International Recruitment of Health Personnel following regional consultations and to commend the Expert Advisory Group for the work;
- (3) to invite Member States and partners, and request the Secretariat, including by utilizing the WHO Academy and WHO collaborating centres, to renew their efforts to strengthen implementation of the WHO Global Code of Practice, in alignment with the recommendations of the Expert Advisory Group;
- (4) to note the Expert Advisory Group's recommendations, including on clarity, safeguards and appropriate flexibility in the application of the WHO Health Workforce Support and Safeguards List;
- (5) to further note the Expert Advisory Group's emphasis on the need for meaningful co-investment in health workforce development and health system strengthening in source countries, in order to support health workforce sustainability and the delivery of proportional benefits;
- (6) to request the next review of the relevance and effectiveness of the WHO Global Code of Practice to be submitted to the Eighty-fifth World Health Assembly, following the seventh round of reporting under the WHO Global Code of Practice and within available resources;
- (7) to request the Director-General to facilitate Member-State led informal consultations on a decision or resolution, focusing on the Expert Advisory Group's recommendations, including those for additional text to be included in the WHO Global Code of Practice, to be considered for adoption by the Seventy-ninth World Health Assembly.

(Fifth meeting, 4 February 2026)

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

¹⁰ Document EB158/17.

EB158(8) Economics of health for all¹¹

The Executive Board, having considered the report by the Director-General,¹²

Decided to recommend to the Seventy-ninth World Health Assembly the adoption of the following decision:

The Seventy-ninth World Health Assembly, having considered the report by the Director-General,

Decided:

1. to adopt the strategy on the economics of health for all;
2. to request the Director-General to report on progress made in the implementation of the strategy, together with progress made in the implementation of resolution WHA77.13 (2024), to the Eighty-first and Eighty-third World Health Assemblies in 2028 and 2030, respectively.

(Eighth meeting, 5 February 2026)

EB158(9) Radiation and health: strengthening global protection, preparedness and response¹¹

The Executive Board, having considered the report by the Director-General,¹³

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

The Seventy-ninth World Health Assembly,

Having considered the report by the Director-General;

Noting previous resolutions on WHO's mandate in matters related to radiation and health, including radiation protection in medicine;¹⁴ radiation emergency preparedness and response;¹⁵ environmental health, especially the factors of ultraviolet radiation¹⁶ and radon;¹⁷ and the effects of nuclear war on public health;¹⁸

¹¹ See Annex 5 for the financial and administrative implications for the Secretariat of this decision.

¹² Document EB158/31.

¹³ Document EB158/27.

¹⁴ See resolutions WHA13.56 (1960) and WHA24.31 (1971).

¹⁵ See resolutions WHA55.16 (2002) and WHA61.2 (2008).

¹⁶ See resolutions WHA51.29 (1998) and WHA78.15 (2025).

¹⁷ See resolutions WHA70.12 (2017) and WHA78.5 (2025).

¹⁸ See resolution WHA78.28 (2025).

Recognizing the widespread global exposure to both ionizing and non-ionizing radiation from environmental, occupational and medical sources, as well as potential exposure from emergency situations;

Acknowledging health risks associated with radiation exposure, including short-term and long-term radiation-induced effects in existing, planned and emergency situations, particularly for children and pregnant women, as well as the non-radiological health impacts of radiation emergencies;

Highlighting the importance of strengthening the health sector's capacity to respond to radiation emergencies;

Recognizing WHO's work in providing international leadership in the field of non-ionizing radiation and human health by providing evidence-based reviews and guidance on public health policy;

Recognizing also that natural sources of radiation – such as solar ultraviolet radiation and naturally occurring radioactive material and radon gases – are significant contributors to cancer risk, and recognizing that, while effective preventive interventions exist to mitigate these health risks, there may remain a need for increased investment and strengthened public communication and awareness raising campaigns;

Acknowledging the rapid emergence of new medical technologies, including the combined use of ionizing and non-ionizing radiation with innovations such as artificial intelligence and digital clinical trials, and recognizing the need to ensure radiation safety in healthcare while strengthening medical imaging capacity;¹⁹

Recognizing the increasing use of radiopharmaceuticals in medical diagnostics and treatment, and underscoring the importance of ensuring their safe production, handling, administration and disposal as part of broader efforts to protect public health from radiation-related risks;

Affirming WHO's principal role in providing guidance on radiation and health, in collaboration with FAO, IAEA, ILO, ITU, UNEP, the United Nations Scientific Committee on the Effects of Atomic Radiation (UNSCEAR), WMO and other relevant international partners, such as the International Commission on Non-Ionizing Radiation Protection and the International Commission on Radiological Protection, and in fostering collaboration between radiation regulators, health authorities and other competent bodies, to strengthen the implementation of radiation safety standards;

Noting the need for an integrated global approach to advance the public health agenda on both ionizing and non-ionizing radiation and health, including health risk assessment, research prioritization, and strengthened public communication and awareness-raising on radiation and health matters,

¹⁹ See resolution WHA78.13 (2025).

1. URGES Member States,²⁰ taking into account their national context and circumstances:
 - (1) to strengthen national strategies, legislation, institutional frameworks and capacities for radiation protection and health risk management, including preparedness and response to radiation emergencies, integration into national health emergency frameworks, and long-term monitoring and mental health support;
 - (2) to ensure the integration of interventions addressing radiation-related health risks into broader public health policies and programmes;
 - (3) to ensure the safety and quality of medical uses of radiation, including imaging, radiotherapy and radiopharmaceuticals, through health workforce training, equipment regulation and quality assurance systems, and to promote equitable access to radiation-based technologies, particularly in low-resource settings;
 - (4) to strengthen national systems for monitoring public, workers' and patients' exposures to ionizing and non-ionizing radiation, including radon, ultraviolet radiation, electromagnetic fields and medical sources, and to participate in UNSCEAR global surveys of medical, occupational and public ionizing radiation exposure;
 - (5) to promote public education, risk communication and awareness-raising strategies to reduce harmful exposure and improve understanding of radiation and health issues;
 - (6) to promote international cooperation, including the sharing of national experiences and best practices on radiation and health, through WHO platforms and networks, and in collaboration with relevant international partners;
2. REQUESTS the Director-General:
 - (1) to undertake a global mapping of relevant actors and initiatives, including their mandates and roles in matters related to radiation and health, highlighting in particular WHO's mandate and identifying potential gaps, to advance the public health agenda on radiation protection and emergency preparedness and response, in consultation with Member States and in collaboration with relevant international organizations, non-State actors in official relations with WHO, and WHO collaborating centres;
 - (2) to continue WHO's normative public health role by developing, disseminating and regularly updating guidance on global standards and technical tools for radiation protection and emergency preparedness and response;
 - (3) to continue providing technical support to Member States, upon request, in developing and strengthening national public health strategies, legislation, policies and institutional capacities for assessing, managing and communicating radiation risks from existing, planned and accidental exposures;

²⁰ And, where applicable, regional economic integration organizations.

- (4) to continue promoting research on and surveillance of radiation-related health outcomes, including those arising from emerging technologies;
- (5) to continue collaboration, through existing WHO initiatives and networks, with relevant international organizations and scientific bodies, including FAO, IAEA, ILO, ITU, UNEP, UNSCEAR, WMO and other relevant international partners, such as the International Commission on Non-Ionizing Radiation Protection and the International Commission on Radiological Protection, to harmonize standards, share data and strengthen global coordination on radiation and health;
- (6) to report on progress in the implementation of the present resolution, including on the mapping and gaps analysis, to the Eighty-first World Health Assembly in 2028, and to recommend further action as appropriate.

(Eighth meeting, 5 February 2026)

EB158(10) Draft global plan of action for the health of Indigenous Peoples²¹

The Executive Board, having considered the report by the Director-General,²²

Decided to recommend to the Seventy-ninth World Health Assembly the adoption of the following decision:

The Seventy-ninth World Health Assembly, having considered the report by the Director-General,

Decided to defer consideration of the draft global plan of action for the health of Indigenous Peoples to the Eightieth World Health Assembly in 2027, through the Executive Board at its 160th session, in order to allow additional time for further consultations with Member States, Indigenous Peoples, relevant United Nations and multilateral system agencies, civil society organizations, academic institutions and other stakeholders.

(Eighth meeting, 5 February 2026)

EB158(11) Evaluation: workplan for 2026–2027²¹

The Executive Board, having considered the report by the Director-General,²³ and having also considered the report of the Programme, Budget and Administration Committee of the Executive Board,²⁴

Decided to approve the Organization-wide evaluation workplan for 2026–2027.²⁵

(Eighth meeting, 5 February 2026)

²¹ See Annex 5 for the financial and administrative implications for the Secretariat of this decision.

²² Document EB158/29.

²³ Document EB158/34.

²⁴ Document EB158/4.

²⁵ See Annex 2.

EB158(12) Withdrawal of the Argentine Republic from the World Health Organization²⁶

The Executive Board, taking note of decision WHA78(25) (2025) and the report by the Director-General,²⁷

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

The Seventy-ninth World Health Assembly,

Taking note of the report by the Director-General;

Having noted the communication from the Minister of Foreign Affairs, International Trade and Worship of the Argentine Republic,²⁸ notifying the United Nations Secretary-General that the Argentine Republic withdraws from the World Health Organization, effective as of 17 March 2026,

RESOLVES to acknowledge the withdrawal of the Argentine Republic from the World Health Organization, effective as of 17 March 2026.

(Ninth meeting, 6 February 2026)

EB158(13) Administration of public health prizes and awards²⁶

The Executive Board, having considered the report by the Director-General,²⁹

Decided:

(1) to recommend that the founders of each prize make an annual voluntary contribution sufficient to cover the activity costs incurred by the WHO Secretariat, in order to ensure sustainable financing of the administration of public health prizes and awards, and that, if no such contribution is provided, the founders allocate available funds from the income generated by the investment of the capital of the relevant foundations, where applicable, to the WHO Secretariat and/or review the frequency of awarding the prizes with a view to reducing costs;

(2) to recommend that the respective selection panels and relevant foundations take such steps, as appropriate:

(a) to amend their regulations to enhance the equitable participation of members of the Board in the selection panels, in alignment with the principles of equity and rotation that govern the allocation of elective posts, as described in the Annex to the report by the Director-General;²⁹

²⁶ See Annex 5 for the financial and administrative implications for the Secretariat of this decision.

²⁷ Document EB158/45.

²⁸ Document A78/33 Add.1, Annex 2.

²⁹ Document EB158/51.

- (b) to implement measures to manage actual or perceived conflicts of interest, in alignment with good governance principles;
 - (c) to amend their regulations to add transparent criteria for the selection of the prize laureate(s), where applicable;
- (3) to request the Director-General:
- (a) to implement accountability, streamlining and cost-efficiency measures as part of the administration of the prizes, such as limiting the number of prizes awarded in any given year to six, including by means of a rotation mechanism among prizes if necessary in the future, implementing a minimum of five eligible applications per prize before convening a meeting of the selection panel, ensuring that in the future any proposals for revisions of prize statutes are submitted to the Board for approval, and enhancing the application process through appropriate digital solutions;
 - (b) to report on the implementation of this decision to the Executive Board at its 164th session in 2029.

(Tenth meeting, 6 February 2026)

EB158(14) Award of the Sasakawa Health Prize

The Executive Board, having considered the report of the Sasakawa Health Prize Selection Panel,³⁰ awarded the Sasakawa Health Prize for 2026 to the Banconi Community Health Association (ASACOBA) of Mali for its outstanding innovative work in health development. The laureate will receive a statuette and US\$ 40 000.

(Tenth meeting, 6 February 2026)

EB158(15) Award of the United Arab Emirates Health Foundation Prize

The Executive Board, having considered the report of the United Arab Emirates Health Foundation Selection Panel,³¹ awarded the United Arab Emirates Health Foundation Prize for 2026 to Dr Worawit Tontiwattanasap from Thailand for his outstanding contribution to health development. The laureate will receive a certificate of award, a plaque and US\$ 40 000.

(Tenth meeting, 6 February 2026)

EB158(16) Award of the Dr LEE Jong-wook Memorial Prize for Public Health

The Executive Board, having considered the report of the Dr LEE Jong-wook Memorial Prize Selection Panel,³² awarded the Dr LEE Jong-wook Memorial Prize for Public Health for 2026 to Professor Mohammad Abul Faiz of Bangladesh for his outstanding contribution to public health. The laureate will receive a plaque and US\$ 100 000.

(Tenth meeting, 6 February 2026)

³⁰ Document EB158/50, section 2.

³¹ Document EB158/50, section 3.

³² Document EB158/50, section 5.

**EB158(17) Award of the State of Kuwait Health Promotion Foundation's
His Highness Sheikh Sabah Al-Ahmad Al-Jaber Al-Sabah Prize for the
Promotion of Healthy Ageing**

The Executive Board, having considered the report of the State of Kuwait Health Promotion Foundation Selection Panel,³³ awarded the State of Kuwait Health Promotion Foundation's His Highness Sheikh Sabah Al-Ahmad Al-Jaber Al-Sabah Prize for the Promotion of Healthy Ageing for 2026 jointly to Professor Bruno Vellas of France and to SingHealth of Singapore for their outstanding contributions to research, health promotion, policy and programmes on healthy ageing. Each laureate will receive a certificate of award, a plaque and US\$ 20 000.

(Tenth meeting, 6 February 2026)

EB158(18) Award of the Nelson Mandela Award for Health Promotion

The Executive Board, having considered the report of the Nelson Mandela Award for Health Promotion Selection Panel,³⁴ awarded the Nelson Mandela Award for Health Promotion for 2026 to Dr Amr Mohamed Kandeel of Egypt for his significant contribution to health promotion. The laureate will receive a plaque.

(Tenth meeting, 6 February 2026)

**EB158(19) Proposed amendments to the process for the selection of the
External Auditor³⁵**

The Executive Board, having considered the report by the Director General,³⁶ and having also considered the report of the Programme, Budget and Administration Committee of the Executive Board,³⁷

Decided to recommend to the Seventy-ninth World Health Assembly the adoption of the following decision:

The Seventy-ninth World Health Assembly,

Having considered the report by the Director-General on proposed amendments to the process for the selection of the External Auditor;

Decided to adopt the revised process for selecting the External Auditor and for renewing for a second term, as set out in paragraph 6 of document EB158/41.

(Tenth meeting, 6 February 2026)

³³ Document EB158/50, section 4.

³⁴ Document EB158/50, section 6.

³⁵ See Annex 5 for the financial and administrative implications for the Secretariat of this decision.

³⁶ Document EB158/41.

³⁷ Document EB158/4.

EB158(20) Reform of the global health architecture and the UN80 Initiative

The Executive Board, having considered the report by the Director-General,³⁸ and having also considered the report of the Programme, Budget and Administration Committee of the Executive Board,³⁹ recognizing the central role of Member States in the reform process, and mindful of the ongoing work of the United Nations General Assembly's informal ad hoc working group on mandate implementation review and the call for substantive proposals on structural changes and programme realignments from specialized agencies,

Decided to request the Director-General, in a transparent and inclusive manner and in close consultation with, and under the direction of, Member States:

- (1) to design a proposal on a joint, inclusive, transparent, time-bound, resource effective and efficient process, hosted by WHO, which is led by Member States, that brings together and complements current global health architecture and UN80 discussions to facilitate convergence and consensus-building, in order to support the transformation of the current global health architecture, enhance coordination and leverage the comparative advantages of diverse actors, while being responsive to country needs and realities;
- (2) to convene relevant global health actors, including other global health entities, regional organizations, development banks, philanthropic foundations, civil society and academic institutions, in line with the Framework of Engagement with Non-State Actors, as applicable, in the design of the proposal, taking into account ongoing global health reform initiatives;
- (3) to submit a proposal on the joint process for consideration by the Seventy-ninth World Health Assembly, through the Programme, Budget and Administration Committee at its forty-fourth meeting.

(Tenth meeting, 6 February 2026)

EB158(21) Member State-led governance reform⁴⁰

The Executive Board, having considered the report by the Officers of the Executive Board,⁴¹ and having also considered the report of the Programme, Budget and Administration Committee of the Executive Board,³⁹

Decided:

- (1) to pilot the agreed reforms referenced below in paragraph 2(a) from the reform measures led by the Officers of the Executive Board contained in the Appendix to document EB158/36;⁴²

³⁸ Document EB158/44.

³⁹ Document EB158/4.

⁴⁰ See Annex 5 for the financial and administrative implications for the Secretariat of this decision.

⁴¹ Document EB158/36.

⁴² See Annex 3.

- (2) to continue a Bureau-led process with inclusive Member State consultations at the global and regional levels:
- (a) on the design phase of the pilot, centring on updates to the timeline, checklist and template process for proposing draft resolutions and draft decisions to align with the provisions outlined in the Appendix in paragraphs 8, 9, 11, 12, 13, 14(a)–(c), and 14(f) for application ahead of and during the Eightieth and Eighty-first World Health Assemblies; and on clear parameters for implementing the pilot, including an implementation timeline, reporting and assessment intervals, and metrics for assessing the measures piloted;
 - (b) to encourage co-sponsorship from three countries across two regions during the zero draft phase for draft resolutions and draft decisions as a criteria for the pilot;
 - (c) to discuss further through an all-Member State consultation process on the elements referenced in paragraphs 14(d) and (e), 24, 26 and 29, and whether they might be included at a later stage of the pilot;
- (3) to request the current sitting Officers of the Board to report on future modalities of the pilot, for consideration by the Executive Board at its 159th session, following which an all-Member State group should lead feedback on the pilot, including contributions to an evaluation, which would cover the full duration of the pilot;
- (4) to request the Director-General:
- (a) to support Member State informal discussions outlined in paragraph 2 by providing expert technical advice, financial and administrative implications, inputs and logistic support;
 - (b) to conduct a review of existing governing bodies reporting mandates, including providing advice on those that could be consolidated, delayed or sunset, and to report back to the Eighty-first World Health Assembly in 2028, through the Executive Board at its 162nd session;
 - (c) to prepare options for consolidating follow-up reporting of adopted resolutions and decisions on governing bodies agendas, for consideration by the Eighty-first World Health Assembly in 2028, through the Executive Board at its 162nd session.

(Tenth meeting, 6 February 2026)

EB158(22) Sustainable model for Member State-led governance reform⁴³

The Executive Board, having considered the report by the leads for Member State-led governance reform,⁴⁴ and having also considered the report of the Programme, Budget and Administration Committee,⁴⁵

⁴³ See Annex 5 for the financial and administrative implications for the Secretariat of this decision.

⁴⁴ Document EB158/37.

⁴⁵ Document EB158/4.

Decided:

- (1) to welcome the proposal to evolve the existing arrangements for discussions on ongoing Member State-led governance reform, open to all Member States, into a more sustainable model;
- (2) to support the principles and design features of such a model, as presented in document EB158/37;
- (3) to request Member States with interest and capacity to meet by 15 April 2026, at which meeting a subset of participants, such as an advocacy group, would present themselves to lead the wider membership, with a view to updating a rolling informal workplan for Member States under the model, updating an analysis of progress in implementing the recommendations of the Agile Member States Task Group,⁴⁶ all within the scope of championing work to implement the remaining Task Group recommendations;
- (4) to request such an advocacy group to convene and coordinate discussions on ongoing Member State-led governance reform, and to report to the Executive Board at its 160th session on progress in tracking the achievement and/or implementation of the remaining Task Group recommendations;
- (5) to request the Director-General, in consultation with Member States, to continue to support informal discussions for Member State-led governance reform by providing expert technical advice, inputs and logistic support, while noting the target principles for reform⁴⁷ relating to the capacity of the Secretariat and the implementation costs of reform.

(Tenth meeting, 6 February 2026)

EB158(23) Engagement with non-State actors⁴⁸

The Executive Board, having considered the report by the Director-General,⁴⁹ and having also considered the report of the Programme, Budget and Administration Committee of the Executive Board,⁵⁰ and taking note of the reservations expressed by some Executive Board members, acknowledging that Member States have full sovereign rights over which non-State actors operate within their national territories, and with full consideration and respect to every Member State's national context and legislation,

(1) Decided:

- (a) to admit the entity World Federation of the Sporting Goods Industry into official relations with WHO;

⁴⁶ Document EB152/33, Annex, Appendix, as well as the successive mandates and clarifications provided by the WHO governing bodies, as applicable.

⁴⁷ Document EB158/37, paras. 12 and 13.

⁴⁸ See Annex 5 for the financial and administrative implications for the Secretariat of this decision.

⁴⁹ Document EB158/43.

⁵⁰ Document EB158/4.

(b) to discontinue official relations with the following entities: International Union of Nutritional Sciences and IntraHealth International, Inc.;

(2) Noted with appreciation the collaboration with WHO of the 65 non-State actors listed in Annex 2, commended their continuing contribution to the work of WHO, and decided to renew them in official relations with WHO.⁵¹

(Eleventh meeting, 6 February 2026)

EB158(24) Provisional agenda of the Seventy-ninth World Health Assembly

The Executive Board, having considered the report by the Director-General,⁵² and recalling its earlier decision that the Seventy-ninth World Health Assembly should be held in Geneva, opening on Monday, 18 May 2026, and closing no later than Saturday, 23 May 2026,⁵³ approved the provisional agenda of the Seventy-ninth World Health Assembly as amended.

(Eleventh meeting, 6 February 2026)

EB158(25) Date and place of the 159th session of the Executive Board

The Executive Board, having considered the report by the Director-General,⁵⁴

Decided:

(1) that its 159th session should be convened on 25 and 26 May 2026, at WHO headquarters, Geneva;

(2) that, in the event that limitations to physical meetings preclude the holding of the 159th session of the Executive Board as envisaged, adjustments to the arrangements for that session should be made by the Board or, exceptionally, by the Officers of the Board, in consultation with the Director-General.

(Eleventh meeting, 6 February 2026)

⁵¹ See Annex 4.

⁵² Document EB158/47.

⁵³ See decision EB157(11) (2025).

⁵⁴ Document EB158/48.

Annexes

Annex 1

Confirmation of amendments to the Staff Rules¹

[EB158/53 – 16 January 2026]

1. Amendments to the Staff Rules made by the Director-General are submitted for confirmation by the Executive Board in accordance with Staff Regulation 12.2.²
2. The amendments described in the present [annex] stem from decisions expected to be taken by the United Nations General Assembly at its eightieth session, on the basis of the recommendations made by the International Civil Service Commission in its report for 2025.³ Should the United Nations General Assembly not approve the Commission's recommendations, an addendum to the present report will be issued.
3. The financial implications of the amendments for the biennium 2026–2027 involve additional costs under the Programme budget 2026–2027. They are set out in the document on the financial and administrative implications for the Secretariat of the resolutions proposed for adoption by the Executive Board or the Health Assembly, along with the financial implications beyond the biennium 2026–2027,⁴ and in the paragraphs below.
4. The amendments to the Staff Rules are set forth in the [appendix] to the present [annex].

¹ See resolutions EB158.R7 and EB158.R8.

² See the [Staff Regulations and Staff Rules](#) (accessed 20 November 2025).

³ United Nations General Assembly document A/80/30.

⁴ [See Annex 5].

Amendments considered necessary in the light of decisions expected to be taken by the United Nations General Assembly at its eightieth session on the basis of the recommendations made by the International Civil Service Commission

Remuneration of staff in the professional and higher categories

5. In its report for 2025, the International Civil Service Commission recommended to the United Nations General Assembly that the revised base/floor salary scale and the updated pay protection points for the Professional and higher categories be increased by 1.6% through the standard consolidation method of increasing the base salary and commensurately decreasing post adjustment multiplier points, resulting in no change in net take-home pay, with effect from 1 January 2026. The recommendation reflects the movement of the comparator salaries in 2025.
6. Amendments to Appendix 1 to the Staff Rules have been prepared accordingly and are set forth in [the appendix] to the present [annex].

Remuneration of staff in ungraded positions and the Director-General

7. Subject to the decision of the United Nations General Assembly in respect of the recommendation outlined in paragraph 5 above, the Director-General proposes, in accordance with Staff Regulation 3.1, that the Executive Board recommend to the Seventy-ninth World Health Assembly modifications in the salaries of Assistant Directors-General and Regional Directors. Thus, as from 1 January 2026, the gross salary for Assistant Directors-General and Regional Directors would be US\$ 217 448 per annum, with a corresponding net salary of US\$ 159 016.
8. Based on the adjustments to salaries described above, the salary modification to be authorized by the Health Assembly for a Deputy Director-General would entail, as from 1 January 2026, a gross salary of US\$ 239 200 per annum, with a corresponding net salary of US\$ 173 372.
9. The salary adjustments outlined above would also affect the salary of the Director-General. The gross salary to be authorized by the Health Assembly, as from 1 January 2026, would be US\$ 298 001 per annum, with a corresponding net salary of US\$ 222 101.

Action by the Executive Board

[This paragraph contained two draft resolutions; which were adopted as resolutions EB158.R7 and EB158.R8.]

Appendix

Appendix 1 to the Staff Rules

A. Salary scale for the professional and higher categories showing annual gross salaries and net equivalents after application of staff assessment (in United States dollars)

(effective 1 January 2026)^a

Steps

<i>Level</i>		<i>I</i>	<i>II</i>	<i>III</i>	<i>IV</i>	<i>V</i>	<i>VI</i>	<i>VII</i>	<i>VIII</i>	<i>IX</i>	<i>X</i>	<i>XI</i>	<i>XII</i>	<i>XIII</i>
D-2	Gross	174 208	178 139	182 071	186 008	189 945	193 879	197 811	201 748	205 680	209 614			
	Net	130 477	133 072	135 667	138 265	140 864	143 460	146 055	148 654	151 249	153 845			
D-1	Gross	155 232	158 685	162 145	165 603	169 047	172 506	175 961	179 411	182 870	186 321	189 776	193 224	196 682
	Net	117 953	120 232	122 516	124 798	127 071	129 354	131 634	133 911	136 194	138 472	140 752	143 028	145 310
P-5	Gross	133 807	136 579	139 353	142 119	144 893	147 659	150 461	153 397	156 338	159 274	162 215	165 148	168 092
	Net	103 165	105 105	107 047	108 983	110 925	112 861	114 804	116 742	118 683	120 621	122 562	124 498	126 441
P-4	Gross	109 324	111 997	114 673	117 344	120 019	122 691	125 370	128 043	130 717	133 386	136 066	138 733	141 407
	Net	86 027	87 898	89 771	91 641	93 513	95 384	97 259	99 130	101 002	102 870	104 746	106 613	108 485
P-3	Gross	89 257	91 537	93 817	96 093	98 376	100 710	103 184	105 661	108 136	110 609	113 089	115 563	118 039
	Net	71 335	73 068	74 801	76 531	78 266	79 997	81 729	83 463	85 195	86 926	88 662	90 394	92 127
P-2	Gross	69 139	71 176	73 213	75 253	77 293	79 334	81 376	83 408	85 449	87 487	89 526	91 570	93 605
	Net	56 046	57 594	59 142	60 692	62 243	63 794	65 346	66 890	68 441	69 990	71 540	73 093	74 640
P-1	Gross	53 071	54 803	56 533	58 263	59 992	61 726	63 454	65 186	66 916	68 649	70 376	72 105	73 838
	Net	43 834	45 150	46 465	47 780	49 094	50 412	51 725	53 041	54 356	55 673	56 986	58 300	59 617

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

**B. Pay protection points for staff whose salaries are higher than
the maximum salaries on the unified salary scale
(in United States dollars)
(effective 1 January 2026)**

<i>Level</i>		<i>Pay protection point 1</i>	<i>Pay protection point 2</i>
P-4	Gross	144 086	146 760
	Net	110 360	112 232
P-3	Gross	120 511	122 983
	Net	93 858	95 588
P-2	Gross	95 643	—
	Net	76 189	—
P-1	Gross	75 567	—
	Net	60 931	—

Annex 2

Evaluation: update and proposed workplan for 2026–2027¹

[EB158/34 – 22 December 2025]

[Paragraphs 1–15 set out the background.]

Corporate evaluations

16. Corporate evaluations are managed by the Evaluation Office and focus on strategic, Organization-wide issues aimed at improving strategies, policies, systems processes and performance. Three are planned:

Priority 1

- Evaluability assessment of GPW 14 (*2024–2025 carry-over; requirement*)
- Evaluation of WHO country office strategic planning, including the Country Cooperation Strategy mechanism (*2024–2025 carry-over; significance*)

Priority 2

- Evaluation of gender mainstreaming in WHO (*requirement/significance*).

Decentralized and country programme evaluations

17. CPEs assess WHO's contributions to national health outcomes and inform the development and implementation of country cooperation strategies. They may be commissioned, managed or conducted by, or jointly with, the respective country office, Regional Office and the Evaluation Office. Coverage norms require one CPE per region per year.

18. Decentralized evaluations are commissioned, managed or conducted by divisions, departments or offices at headquarters, regional or country offices, or hosted partnerships, rather than by the Evaluation Office, which provides quality assurance and technical support.

¹ See decision EB158(11).

Headquarters

Decentralized – Priority 1 – Roll-over from 2024–2025

- Developmental evaluation of the previously approved programme (UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction) (*requirement*)

Decentralized – Priority 1 (new)

- Assistive technology programme, with an emphasis on activities funded through the Government of Ireland's five-year award (Health Products Policy and Standard (HPS) Department) (*utility*)

Decentralized – Priority 2

- International Pharmacopoeia as a strategic WHO mechanism for assuring the quality and safety of essential medicines in Member States (HPS Department) (*significance/utility*)

Regional Office for Africa

CPEs – Priority 1 – Roll-over from 2024–2025

- Ethiopia, Rwanda and Sierra Leone

CPEs – Priority 1 – new

- Cameroon

CPEs – Priority 2

- Cabo Verde, Democratic Republic of the Congo, Guinea, Nigeria and South Sudan

Regional Office for the Americas/Pan American Health Organization

CPEs – Priority 2

- One country to be determined

Decentralized – Priority 1 – Roll-over from 2024–2025

- Pan American Health Organization's Technical Cooperation for Human Resources for Health in the Americas (EHRH-TC) (*significance, utility*)

Decentralized – Priority 2

- Pan American Health Organization's capacity to implement effective voluntary contributions (*significance, utility*)
- Management information systems (*significance, utility*)

Regional Office for South-East Asia

CPEs – Priority 1

- Democratic People’s Republic of Korea

Decentralized – Priority 1

- Strategic Framework for the WHO South-East Asia Regional Vaccine Action Plan 2022–2030 as aligned with the global Immunization Agenda 2030 (*requirement*)
- WHO’s Primary Health Care revitalization support to Maldives (*significance*)
- WHO Immunization, Vaccines and Biologicals network support for immunization and surveillance, Nepal (*significance*)
- Health National Adaptation Plan, Thailand (*significance*)
- WHO contribution to the School Health Project, Timor-Leste, 2022–2026 (*significance*)

Decentralized – Priority 2

- WHO country office contribution to kala-azar and lymphatic filariasis elimination programme, India (2020–2024) (*significance*)
- WHO country office contribution during 2021 to 2024 to specific areas such as HIV prevention and treatment, Myanmar (*significance*)

Regional Office for Europe

CPEs – Priority 1

- Czechia

CPEs – Priority 2

- Ukraine

Decentralized – Priority 1

- Improving maternal and newborn health in Central Asia (*significance*)

Evaluative activity – Priority 2

- Meta-Synthesis of WHO/Europe Evaluations on Disability Inclusion, Gender Equality and Human Rights (*requirement/significance*)

Regional Office for the Eastern Mediterranean

CPEs – Priority 1 – roll-over from 2024–2025

- Oman

CPEs – Priority 2

- Kuwait, Lebanon, Morocco, occupied Palestinian territory, Qatar, Saudi Arabia and United Arab Emirates

Decentralized – Priority 1

- WHO–EU Neighbourhood, Development and International Cooperation Instrument (NDICI) 2024–2027, Jordan (*utility*)

Decentralized – Priority 2

- WHO projects in Lebanon funded by the Pandemic Fund and the European Union (*requirement*)
- WHO's response to the conflict in Sudan (*utility*)
- Mid-term evaluation of the WHO Eastern Mediterranean Regional Strategic Operational Plan 2025–2028 (*requirement*)

Regional Office for the Western Pacific**CPEs – Priority 1 – roll-over from 2024–2025**

- Mongolia

CPEs – Priority 1 (new)

- Indonesia (to be confirmed) and Lao People's Democratic Republic (to be confirmed)

Decentralized – Priority 1

- Regional Office mechanism for regular programme budget performance review, monitoring and reporting (*significance*)

Decentralized – Priority 2

- WHO's contribution to implement HEARTS: for cardiovascular disease management in the Western Pacific Region (*significance*)

Joint United Nations evaluations

19. For joint evaluations, WHO engages United Nations entities, agencies and inter-agency evaluation networks through participation in reference or management groups and/or small contributions. Joint evaluations are led by partners or WHO; in the biennium 2026–2027, all will be partner-led.

Joint – Priority 1

Three evaluations rolled over from 2024–2025:

- Inter-Agency Humanitarian Evaluation of the humanitarian response in the Democratic Republic of the Congo (United Nations Office for the Coordination of Humanitarian Affairs (OCHA) lead; staff time and funding)
- Inter-Agency Humanitarian Evaluation of the humanitarian response in Sudan (OCHA lead; staff time and funding)
- United Nations Food Systems Summit (UNFSS) Follow Up: Joint Evaluation of Food Systems Coordination Hub (United Nations System-wide Evaluation Office lead; WHO staff time contribution only)

One new planned evaluation:

- Inter-Agency meta-synthesis of evaluation reports of priority area of health of the United Nations Youth Strategy (UNICEF/UNFPA lead; WHO staff time contribution only)

20. Subject to funding, the 2026–2027 workplan envisages 52 evaluations (of which 12 are ongoing and rolled over). As at December 2025, of the 40 remaining evaluations, 15 (37.5%) are fully funded while resources must be mobilized to initiate 25 (62.5%). Ongoing prioritization is required as funding becomes available. If fully implemented, the workplan would have adequate coverage across WHO and GPW 14 priorities, enabling assessment of WHO's contributions and supporting evidence-based policies, strategies and programmes.

Table 1. Summary of planned evaluations, 2026–2027

Type	Total number	Of which,	Of which,	Of which,	Lead offices
		Carry over	Rolled over (Ongoing)	New	
Corporate	3	2	0	1	Evaluation Office
Country Programme	24	–	5	19	Jointly by three levels of WHO ^a
Decentralized	21	–	2	19	Headquarters: 3; regional offices 18 ^b
Joint	4	–	3	1	Evaluation Office: 4
Total	52	2	10	40	

^a Breakdown of country programme evaluation by region: Africa 9; Americas/PAHO 1; South-East Asia 1; Europe 2; Eastern Mediterranean 8; Western Pacific 3.

^b Breakdown by region: Americas/PAHO 3; South-East Asia 7; Europe 2; Eastern Mediterranean 4; Western Pacific 2.

[Paragraphs 21–24 summarized the evaluation function and systems. Paragraph 25 contained a draft decision that was adopted as decision EB158(11).]

Annex 3

Member State-led governance reform¹

[EB158/36, Appendix – 22 December 2025]

[Paragraphs 1–4 set out the background.]

Stream 1: Resolution and decision management

[Paragraphs 5–7 described the issues identified.]

Progress in implementation of the mandate

8. **Resolution and/or decision checklist, timeline and templates established.** The current process for proposing draft resolutions includes a checklist, timeline and templates.² However, as outlined in paragraph 7 above, proposals at present do not sufficiently inform Member States about alignment with WHO's core mandate, comparative advantage and the GPW. Improved discipline by Member States is required to ensure the checklist includes strategic assessment, adherence to timelines and consistent application of required templates.

Measures for immediate implementation

9. **Ensure accurate, consistent and timely availability of costing information.** The current timeline requires the Secretariat to make costing advice available to Member States from the earliest stage of development for draft resolutions and draft decisions. Providing these costs (including on each Secretariat action outlined in the proposal) to proponents, for inclusion with the zero draft and concept note, will improve current practices by ensuring all Member States have relevant costing information before consultations. In contrast, no costings were distributed to all Member States for draft resolutions or draft decisions submitted to the Seventh-eighth World Health Assembly at the zero draft stage. Costings were only distributed in writing with the documents for the 156th session of the Executive Board.

10. Recognizing that accurate initial costings require well-structured proposals and that changes negotiated to draft proposals may vary costs substantially, the Secretariat should propose ways to inform Member States how to, or empower them to, transparently, consistently and reliably calculate the impact of certain edits to the original cost estimate during consultations. Upon completion of the consultation process, costs should be adjusted based on the finalized text and

¹ See decision EB158(21).

² See decision EB153(2) (2023).

circulated to Member States prior to the January/February Board sessions. Additionally, any variations to the methodology used for costings should be made transparent to Member States.

Measures for governing bodies action

11. **Enforce adherence to the current timeline, checklist and template processes.** To ensure the quality and timeliness of draft proposals that progress to Member States for consultation, Member States must empower the Secretariat to strictly adhere to and apply the process and timelines by transparently identifying proposals that fully satisfy trigger deadlines (for example, provide a complete submission on time). In practice this would mean that only proposals that meet the deadline requirements would trigger access to further support on costing and consultations. A consistent approach to drafting and adherence to templates and timelines will enable Member States to engage fully in consultations and text negotiations.

12. Incomplete proposals that do not adhere to the checklist and template will not progress further. The Secretariat will provide advice on each proposal's adherence to the checklist and template to Board members. To assist in ensuring that draft resolutions and draft decisions meet the requirements, Member States could request the Secretariat's feedback prior to formal submission. This will assist the identification and correction of any inconsistencies or deficiencies before the submission deadline, supporting draft resolutions and draft decisions to meet all requirements prior to progressing to the next stage. The Secretariat could build upon innovative digital solutions, such as the draft resolution submission portal, to support Member States' successful completion of all required components of a given submission.

13. At the 157th session of the Executive Board, Member States identified the need for appropriate information to enable informed prioritization of future draft resolutions and draft decisions. Member States need information on proposals' alignment with the GPW, their capacity to address "gaps" or emerging priorities and accurate information on resource implications.

14. WHO is a Member State-led Organization and the resolution and decision process must remain Member State-driven. It is crucial that process changes do not restrict Member States submitting initial proposals. As such, improvements should focus on delivering Member States' commitment to an orderly, predictable and transparent process that reduces burden on Member States and the Secretariat. It should also aim to improve the prospects of all resolutions and decisions being successfully implemented under realistic funding expectations, and should better support Member States to make informed decisions on the adoption of draft resolutions and draft decisions. The timeline, template and checklist process should be updated to include:

(a) **Strengthened criteria to improve the quality of draft resolutions and draft decisions.**

The template and checklist for Member States preparing World Health Assembly draft resolutions and/or draft decisions³ is a good start to ensure that draft resolutions and draft decisions follow proper procedure. There is a need to ensure proposals that progress have a clear purpose and will address a gap in WHO's existing work programme. Proposals should also align with WHO's core mandate and comparative advantage and deliver the greatest impact globally within available budget. To ensure objectivity in decision-making, each criterion should have clear links to pre-existing factual information. The following additional

³ See [Template and checklist for Member States preparing Health Assembly resolutions and/or decisions](#). Geneva: World Health Organization; 2023 (accessed 12 November 2025).

criteria should be used as a tool by the Executive Board to assess each draft resolution or draft decision to ensure it:

- (i) Aligns with the results of programme budget prioritization processes, as demonstrated by a clear link to a GPW outcome and the priority ranking of the outcome as outlined by programme budget prioritization.
- (ii) Addresses a clear gap within the GPW or an emerging global health priority for which the WHO has a defined and accepted role with a comparative advantage. All actions included in the proposal should complement established and ongoing WHO activities. Proposals should seek synergies with other United Nations agencies, in accordance with each agency's mandate. This is demonstrated by confirming that actions in the draft resolution are not duplicative of active resolutions and decisions and the work of other UN or relevant global health agencies.
- (iii) Includes a clear and measurable outcome, with clear global relevance to Member States across regions. This can be demonstrated through co-sponsorship by Member States from at least three of the six WHO regions (inclusive of the proposer's region) at the zero draft stage. Where multiple outcomes are included, they must be cohesive and directly related to the purpose of the draft resolution, as identified by the concept note.
- (iv) Addresses an issue that represents a significant public health burden, as demonstrated by links to relevant WHO or UN reported data, such as, but not limited to, WHO Global Health Observatory data or 2030 Agenda for Sustainable Development reporting.
- (v) Clearly indicates the financial and resourcing implications for the Secretariat, ensuring that new activities are within the Organization's implementation capacity, avoiding adoption of resolutions that realistically may not be successfully implemented.
- (vi) Presents a clear rationale why this issue should uniquely be addressed by a World Health Assembly resolution or decision (compared to other advocacy or awareness measures) within the current governing bodies cycle. The rationale should reference convenience, timeliness, opportunity or alignment with other milestones.

(b) **Secretariat to present guidance for Member State consideration on the number of draft resolutions and draft decisions that could be reasonably considered within the negotiation period in the current cycle, without resorting to out-of-hours meetings.** This measure would recognize the finite time available for meaningful debate and negotiation of draft texts, the capacity of individual Member States and the disproportionate burden on smaller States to engage. The Secretariat's analysis should be based on the principle of limiting Member State burden and should be informed by the number of negotiating sessions required in the previous cycle, as well as known and anticipated parallel meetings or other constraints to time available in the current cycle. The analysis should be made available to all Member States and act as guidance to enable informed decision-making. However, the final number of proposals recommended for progression remains at the discretion of the Executive Board.

(c) **Proposers must ensure draft resolutions and/or draft decisions adhere to the agreed criteria, with support from the Secretariat.** After submission of the initial draft proposal, the Secretariat should review and provide information to assist the proposer in determining whether the draft resolution or draft decision adhere to the criteria, in order to ensure Member States have the necessary information to make informed decisions. Information provided can be objective advice on the proposal's adherence to the criteria, as well as input that the proposing Member State(s) cannot supply themselves, including initial costing, the relevant GPW outcome and prioritization ranking, identification of any duplicate work and relevant WHO or UN reported data. To enable transparency and ease of review by other Member States, the Secretariat will amend the proposal template to include a cover page with agreed criteria. This will then be completed by the proposing Member State(s) using the information and costing provided by the Secretariat. The cover page should include dedicated space for the Secretariat to transparently provide advice and for the proposers to provide a rationale for any criteria not met. It will be essential that the Secretariat provide timely advice for Member States submitting proposals.

[Paragraphs 14(d) and (e) set out additional proposed measures for governing bodies action.]

(f) **The Programme, Budget and Administration Committee (PBAC) should review the budgetary implications of draft resolutions and draft decisions.** The PBAC should review each draft resolution from a financial perspective and provide recommendations to the Executive Board based on the Organizational capacity to successfully implement it. The Executive Board should consider these recommendations in a balanced manner with respect to the health problem they address. Given that some draft resolutions may still be undergoing negotiations in the intersessional period before each Health Assembly, updated costings could be provided to the second PBAC meeting of the year, prior to adoption at the Health Assembly, if costings considered at the previous PBAC meeting are no longer accurate. As part of changes to the current draft resolution and draft decision timeline process, Member States will need to agree the time frame in which draft resolutions and draft decisions should be submitted for costing.

15. Member States' commitment to a transparent, predictable and orderly process does not mean surrendering the existing pathway for proposing draft resolutions or draft decisions under the current rules of procedure. However, it must be recognized that this pathway can systemically lead to the exclusion of Member States, including under-resourced Member States, by leaving as little as one day to consider, negotiate and approve texts. Member States must commit to preserving this extraordinary pathway by exercising its use only in extreme and unforeseen circumstances that require clear and urgent actions.

[Paragraphs 16–29 described proposed measures for agenda and mandate management and for meeting management, respectively. Paragraphs 30–37 summarized the way forward related to the pilot process of the proposed reform measures.]

Annex 4

Non-State actors maintained in official relations with WHO by virtue of decision EB158(23)

[EB158/43, Annex 2 – 23 December 2025]

1. AIFO-Italian Association Friends of Raoul Follereau ETS
2. Alzheimer's Disease International: The International Federation of Alzheimer's Disease and Related Disorders Societies, Inc.
3. American Society for Reproductive Medicine
4. Anesvad Foundation
5. Clinton Health Access Initiative, Inc.
6. Corporate Accountability
7. Drugs for Neglected Diseases initiative
8. Family Health International
9. Gates Foundation
10. Global Alliance for Tobacco Control
11. Grand Challenges Canada
12. Handicap International Federation
13. HelpAge International
14. International Association for Suicide Prevention
15. International Association for the Scientific Study of Intellectual and Developmental Disabilities
16. International Baby Food Action Network
17. International Bureau for Epilepsy
18. International Commission on Occupational Health
19. International Committee for Monitoring Assisted Reproductive Technologies
20. International Confederation of Midwives
21. International Council for Commonality in Blood Banking Automation, Inc.
22. International Ergonomics Association
23. International Federation of Gynecology and Obstetrics

24. International Federation on Ageing
25. International Lactation Consultant Association
26. International League Against Epilepsy
27. International Network of Women Against Tobacco
28. International Pediatric Association
29. International Physicians for the Prevention of Nuclear War
30. International Planned Parenthood Federation
31. International Psycho-Oncology Society, Inc.
32. International Rescue Committee, Inc.
33. International Society for Biomedical Research on Alcoholism
34. International Society of Andrology
35. International Spinal Cord Society
36. International Union for Health Promotion and Education
37. International Union of Psychological Science
38. Iodine Global Network
39. Knowledge Ecology International, Inc.
40. Lifting the Burden
41. Médecins Sans Frontières International
42. Medical Women's International Association
43. Medicines Patent Pool Foundation
44. Multiple Sclerosis International Federation
45. NCD Alliance
46. Stichting Health Action International
47. The Carter Center, Inc.
48. The Fred Hollows Foundation
49. The Global Alliance for Improved Nutrition
50. The International Association for Child and Adolescent Psychiatry and Allied Professions
51. The International Society for Prosthetics and Orthotics
52. The International Society for the Prevention of Child Abuse and Neglect
53. The Population Council, Inc.
54. The Transplantation Society
55. Women in Global Health, Inc.
56. World Association for Sexual Health
57. World Association of Echinococcosis
58. World Confederation for Physical Therapy

59. World Federation for Mental Health
 60. World Federation of Neurology
 61. World Federation of Neurosurgical Societies
 62. World Federation of Occupational Therapists
 63. World Federation of the Deaf
 64. World Obesity Federation
 65. World Psychiatric Association
-

Annex 5

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

Resolution EB158.R1 Steatotic liver disease: a missing piece in the global noncommunicable disease response

A. Link to the approved Programme budget 2026–2027

- 1. Output(s) in the approved Programme budget 2026–2027 under which this resolution would be implemented:**
 - 2.2.1. WHO develops norms, standards and technical packages to address risk factors for communicable and noncommunicable diseases, violence and injuries, prevent poor nutrition and strengthen food safety and reduce environmental health risks, and supports countries in their implementation, including in the monitoring and development of legislation and regulations
 - 2.2.2. WHO supports countries to ensure comprehensive access to promotion and preventive health services for populations (such as tobacco and alcohol cessation services, physical activity counselling and nutrition counselling, including for breastfeeding), and to monitor their implementation
 - 2.3.1. WHO develops guidance and supports countries to strengthen their capacity to engage with and empower individuals and communities and all levels of government across sectors to increase health literacy, enable healthier behaviours, advance co-benefits and improve the governance and implementation of settings-based approaches and health promotion policies
 - 3.3.1. WHO builds country capacity and develops tools and platforms to support countries in developing and improving their national digital health and health information systems to improve resilience, coverage, equity and impact
- 2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**

Not applicable.
- 3. Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:**

Not applicable.
- 4. Estimated time frame (in years or months) to implement the resolution:**

Five years (2026–2030).

B. Budget and resource implications for the Secretariat for implementation of the resolution

- 1. Total planned costs required to implement the resolution, in US\$ millions:**

US\$ 1.01 million.
- 2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:**

US\$ 0.32 million.

- 2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:**
Not applicable.
- 3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:**
US\$ 0.33 million.
- 4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:**
US\$ 0.36 million.
- 5. Level of financial resources already available to fund the implementation of the resolution in the current biennium, in US\$ millions**
- **Financial resources available to fund the resolution in the current biennium:**
Zero.
 - **Remaining financing gap in the current biennium:**
US\$ 0.32 million.
 - **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
There are efforts to obtain funds for the agenda of cardiometabolic diseases, of which steatotic liver disease forms part.

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. 2026–2027 cost of resources already planned	Staff	0.01	0.01	0.00	0.01	0.00	0.00	0.01	0.04
	Activities	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.28
	Total	0.05	0.05	0.04	0.05	0.04	0.04	0.05	0.32
B.2.b. 2026–2027 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2028–2029 cost of resources to be planned	Staff	0.01	0.01	0.00	0.01	0.00	0.00	0.01	0.04
	Activities	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.29
	Total	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.33
B.4. Future bienniums cost of resources to be planned	Staff	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.06
	Activities	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.30
	Total	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.36
B.1. Total planned costs required to implement the resolution									1.01

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

Resolution EB158.R2 Precision medicine: a path towards targeted, personalized and equitable care

A. Link to the approved Programme budget 2026–2027

- 1. Output(s) in the approved Programme budget 2026–2027 under which this resolution would be implemented:**
 - 3.3.1. WHO builds country capacity and develops tools and platforms to support countries in developing and improving their national digital health and health information systems to improve resilience, coverage, equity and impact
 - 7.2.2. Strengthening national and regional science ecosystems to improve health and provide opportunities and equity, active support for the digital health transformation, research, development and innovation, including manufacturing capacities of countries
- 2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**
Not applicable.
- 3. Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:**
Not applicable.
- 4. Estimated time frame (in years or months) to implement the resolution:**
Three years.

B. Budget and resource implications for the Secretariat for implementation of the resolution

- 1. Total planned costs required to implement the resolution, in US\$ millions:**
US\$ 2.98 million.
- 2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:**
US\$ 1.89 million.
- 2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:**
Zero.
- 3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:**
US\$ 1.09 million.
- 4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:**
Zero.
- 5. Level of financial resources already available to fund the implementation of the resolution in the current biennium, in US\$ millions**
 - **Financial resources available to fund the resolution in the current biennium:**
US\$ 1.42 million.
 - **Remaining financing gap in the current biennium:**
US\$ 0.47 million.
 - **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
WHO has previously been approached by donors interested in supporting the genomics programme, which was not required at that point. These donors can be approached to reconsider opportunities related to precision medicine.

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. 2026–2027 cost of resources already planned	Staff	0.05	0.05	0.04	0.05	0.04	0.04	1.00	1.26
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.63	0.63
	Total	0.05	0.05	0.04	0.05	0.04	0.04	1.63	1.89
B.2.b. 2026–2027 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2028–2029 cost of resources to be planned	Staff	0.02	0.02	0.02	0.02	0.02	0.02	0.52	0.65
	Activities	0.05	0.05	0.05	0.05	0.05	0.05	0.12	0.44
	Total	0.08	0.08	0.07	0.08	0.07	0.07	0.64	1.09
B.4. Future bienniums cost of resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.1. Total planned costs required to implement the resolution									2.98

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

Resolution EB158.R3 Strengthening equitable access to diagnostic imaging through teleradiology

A. Link to the approved Programme budget 2026–2027

- 1. Output(s) in the approved Programme budget 2026–2027 under which this resolution would be implemented:**
 - 3.2.3 WHO supports countries to implement measures for better access to, and use of, safe, effective and quality-assured health products
 - 3.3.1 WHO builds country capacity and develops tools and platforms to support countries in developing and improving their national digital health and health information systems to improve resilience, coverage, equity and impact
 - 7.2.1 Evidence-based and quality-assured normative products, including the living approach, are developed with and for countries, are digitally accessible and used for health, policy and practice impact
 - 7.2.2 Strengthening national and regional science ecosystems to improve health and provide opportunities and equity, active support for the digital health transformation, research, development and innovation, including manufacturing capacities of countries
- 2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**
Not applicable.

3. Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:
Not applicable.

4. Estimated time frame (in years or months) to implement the resolution:
Five years.

B. Budget and resource implications for the Secretariat for implementation of the resolution

1. Total planned costs required to implement the resolution, in US\$ millions:
US\$ 3.47 million.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:
US\$ 0.90 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:
Zero.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:
US\$ 1.86 million.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:
US\$ 0.72 million.

5. Level of financial resources already available to fund the implementation of the resolution in the current biennium, in US\$ millions

- Financial resources available to fund the resolution in the current biennium:
US\$ 0.10 million.
- Remaining financing gap in the current biennium:
US\$ 0.80 million.
- Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:
US\$ 0.35 million.

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. 2026–2027 cost of resources already planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.20	0.20
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.70	0.70
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.90	0.90
B.2.b. 2026–2027 cost of additional resources	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
B.3. 2028–2029 cost of resources to be planned	Staff	0.13	0.12	0.10	0.12	0.09	0.11	0.20	0.87
	Activities	0.16	0.16	0.16	0.16	0.16	0.16	0.04	0.98
	Total	0.28	0.28	0.26	0.28	0.25	0.26	0.24	1.86
B.4. Future bienniums cost of resources to be planned	Staff	0.06	0.06	0.05	0.06	0.05	0.05	0.10	0.45
	Activities	0.04	0.04	0.04	0.04	0.04	0.04	0.01	0.27
	Total	0.11	0.11	0.10	0.10	0.09	0.10	0.11	0.72
B.1. Total planned costs required to implement the resolution									3.47

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

Resolution EB158.R4 Reducing the burden of stroke: strengthening prevention, acute care, rehabilitation and health system readiness

A. Link to the approved Programme budget 2026–2027

- Output(s) in the approved Programme budget 2026–2027 under which this resolution would be implemented:**
 - 4.1.1. WHO develops evidence-based policies and supports the implementation, scale-up and measurement of best buys and other actions to strengthen person-centred prevention, control and management of noncommunicable diseases
 - 4.1.2 WHO supports the design, scale-up, implementation and measurement of the coverage of people-centred, equitable services for key mental health, neurological and substance use conditions
- Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**
Not applicable.
- Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:**
Not applicable.
- Estimated time frame (in years or months) to implement the resolution:**
Five years (2026–2030).

B. Budget and resource implications for the Secretariat for implementation of the resolution

- Total planned costs required to implement the resolution, in US\$ millions:**
US\$ 4.53 million.

- 2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:**
US\$ 1.57 million.
- 2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:**
Not applicable.
- 3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:**
US\$ 1.63 million.
- 4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:**
US\$ 1.33 million.
- 5. Level of financial resources already available to fund the implementation of the resolution in the current biennium, in US\$ millions**
- **Financial resources available to fund the resolution in the current biennium:**
US\$ 1.25 million.
 - **Remaining financing gap in the current biennium:**
US\$ 0.32 million.
 - **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
Efforts are under way to obtain funds for the areas of cardiovascular disease, cerebrovascular diseases and neurological disorders, of which stroke forms part.

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. 2026–2027 cost of resources already planned	Staff	0.05	0.04	0.03	0.04	0.03	0.04	0.22	0.44
	Activities	0.07	0.07	0.07	0.07	0.07	0.07	0.73	1.13
	Total	0.11	0.10	0.10	0.11	0.10	0.10	0.94	1.57
B.2.b. 2026–2027 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2028–2029 cost of resources to be planned	Staff	0.05	0.04	0.03	0.04	0.03	0.04	0.23	0.46
	Activities	0.07	0.07	0.07	0.07	0.07	0.07	0.75	1.17
	Total	0.12	0.11	0.10	0.11	0.10	0.11	0.98	1.63
B.4. Future bienniums cost of resources to be planned	Staff	0.07	0.06	0.05	0.06	0.05	0.06	0.35	0.72
	Activities	0.04	0.04	0.04	0.04	0.04	0.04	0.39	0.61
	Total	0.11	0.10	0.09	0.10	0.09	0.09	0.74	1.33
B.1. Total planned costs required to implement the resolution									4.53

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

Resolution EB158.R5 Advancing smart, efficient pharmacovigilance as an essential tool for robust, sustainable, resilient and responsive health systems, for everyone, everywhere

A. Link to the approved Programme budget 2026–2027

- 1. Output(s) in the approved Programme budget 2026–2027 under which this resolution would be implemented:**
3.2.3. WHO supports countries to implement measures for better access to, and use of, safe, effective and quality-assured health products
- 2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**
Not applicable.
- 3. Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:**
Not applicable.
- 4. Estimated time frame (in years or months) to implement the resolution:**
Seven years (2026–2032).

B. Budget and resource implications for the Secretariat for implementation of the resolution

- 1. Total planned costs required to implement the resolution, in US\$ millions:**
US\$ 17.26 million.
- 2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:**
US\$ 5.58 million.
- 2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:**
Not applicable.
- 3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:**
US\$ 5.82 million.
- 4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:**
US\$ 5.86 million.
- 5. Level of financial resources already available to fund the implementation of the resolution in the current biennium, in US\$ millions**
 - **Financial resources available to fund the resolution in the current biennium:**
US\$ 5.58 million.
 - **Remaining financing gap in the current biennium:**
Not applicable.
 - **Estimated financial 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. 2026–2027 cost of resources already planned	Staff	0.14	0.14	0.12	0.14	0.11	0.12	2.78	3.57
	Activities	0.34	0.13	0.22	0.06	0.17	0.22	0.88	2.01
	Total	0.48	0.27	0.34	0.21	0.28	0.34	3.66	5.58
B.2.b. 2026–2027 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2028–2029 cost of resources to be planned	Staff	0.15	0.15	0.13	0.15	0.12	0.13	2.89	3.72
	Activities	0.35	0.13	0.23	0.07	0.17	0.23	0.92	2.10
	Total	0.50	0.28	0.35	0.22	0.29	0.35	3.81	5.82
B.4. Future bienniums cost of resources to be planned	Staff	0.16	0.16	0.13	0.15	0.12	0.13	2.89	3.74
	Activities	0.37	0.14	0.24	0.07	0.18	0.24	0.88	2.12
	Total	0.53	0.30	0.37	0.22	0.30	0.37	3.77	5.86
B.1. Total planned costs required to implement the resolution									17.26

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

Resolution EB158.R6 Health conditions in the occupied Palestinian territory, including east Jerusalem

A. Link to the approved Programme budget 2026–2027

1. Output(s) in the approved Programme budget 2026–2027 under which this resolution would be implemented:

2.2.1. WHO develops norms, standards and technical packages to address risk factors for communicable and noncommunicable diseases, violence and injuries, prevent poor nutrition and strengthen food safety and reduce environmental health risks, and supports countries in their implementation, including in the monitoring and development of legislation and regulations

4.2.2. WHO provides guidance and technical assistance to strengthen and sustain quality immunization services, including for poliomyelitis, especially for unvaccinated and undervaccinated persons

5.2.3. WHO provides technical expertise and operational support to strengthen and scale clinical care for emergencies, including infection prevention and control measures to protect health workers and patients

6.1.1. WHO strengthens surveillance and alert systems, including diagnostics and laboratory capacities, for the effective monitoring of public health threats and the rapid detection, verification, risk assessment and grading of public health events

2. **Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**
Not applicable.
3. **Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:**
Not applicable.
4. **Estimated time frame (in years or months) to implement the resolution:**
One year (January 2026–December 2026).

B. Budget and resource implications for the Secretariat for implementation of the resolution

1. **Total planned costs required to implement the resolution, in US\$ millions:**
US\$ 333.20 million.
- 2.a. **Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:**
Zero. This resolution would be implemented through the emergency operations and appeals budget segment.
- 2.b. **Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:**
US\$ 333.20 million.
3. **Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:**
Not applicable
4. **Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:**
Not applicable.
5. **Level of financial resources already available to fund the implementation of the resolution in the current biennium, in US\$ millions**
 - **Financial resources available to fund the resolution in the current biennium:**
US\$ 82.70 million.
 - **Remaining financing gap in the current biennium:**
US\$ 250.50 million.
 - **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
Pledges are in the pipeline; fundraising is continuing.

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. 2026–2027 cost of resources already planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.2.b. 2026–2027 cost of additional resources	Staff	0.00	0.00	0.00	0.00	27.00	0.00	1.10	28.10
	Activities	0.00	0.00	0.00	0.00	303.00	0.00	2.10	305.10
	Total	0.00	0.00	0.00	0.00	330.00	0.00	3.20	333.20
B.3. 2028–2029 cost of resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.4. Future bienniums cost of resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.1. Total planned costs required to implement the resolution									333.20

Resolution EB158.R7 Confirmation of amendments to the Staff Rules: remuneration of staff in the professional and higher categories

Resolution EB158.R8 Salaries of staff in ungraded positions and of the Director-General

A. Link to the approved Programme budget 2026–2027

- Output(s) in the approved Programme budget 2026–2027 under which these resolutions would be implemented:**
8.1.1. Policies, rules and regulations in place to attract, recruit and retain a diverse, empowered and fit-for-purpose workforce, operating in a respectful and inclusive workplace with Organizational change fully institutionalized
- Short justification for considering the resolutions, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**
Not applicable.
- Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:**
Not applicable.
- Estimated time frame (in years or months) to implement the resolutions:**
With respect to **resolution 1** (concerning the remuneration of staff in the Professional and higher categories), the relevant amendments to the Staff Rules will take effect from 1 January 2026. With respect to **resolution 2** (concerning remuneration of staff in ungraded positions and of the Director-General) the relevant amendments in remuneration will take effect from 1 January 2026. There is no defined end date for implementation of either resolutions.

B. Budget and resource implications for the Secretariat for implementation of the resolutions**1. Total planned costs required to implement the resolutions, in US\$ millions:**

The resource requirements for the resolutions are already included within what is planned under the approved Programme budget 2026–2027.

All resource requirements to implement the resolutions would be covered within the post cost averages that form the basis of staff planning for the approved Programme budget 2026–2027. Since these are spread across all results and all levels of the Organization, the additional resource levels required for these resolutions are already covered within the same approved Programme budget 2026–2027.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:

Not applicable.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:

Not applicable.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:

Not applicable.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:

Not applicable.

5. Level of financial resources already available to fund the implementation of the resolutions in the current biennium, in US\$ millions**– Financial resources available to fund the resolutions in the current biennium:**

Not applicable.

– Remaining financing gap in the current biennium:

Not applicable.

– Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:

Not applicable.

Decision EB158(1) Follow-up to the political declaration of the fourth high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases and the promotion of mental health and well-being

A. Link to the approved Programme budget 2026–2027**1. Output(s) in the approved Programme budget 2026–2027 under which this decision would be implemented:**

2.2.1. WHO develops norms, standards and technical packages to address risk factors for communicable and noncommunicable diseases, violence and injuries, prevent poor nutrition, strengthen food safety and reduce environmental health risks, and supports countries in their implementation, including in the monitoring and development of legislation and regulations

3.1.1. WHO strengthens country capacity and provides guidance on the design, delivery, quality and measurement of integrated services

4.1.1. WHO develops evidence-based policies and supports the implementation, scale-up and measurement of best buys and other actions to strengthen person-centred prevention, control and management of noncommunicable diseases

4.1.2. WHO supports the design, scale-up, implementation and measurement of the coverage of people-centred, equitable services for key mental health, neurological and substance use conditions

2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2026–2027:

Not applicable.

3. Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:

Not applicable.

4. Estimated time frame (in years or months) to implement the decision:

Five years (2026–2030).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US\$ millions:

US\$ 0.19 million.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:

US\$ 0.06 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:

Not applicable.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:

US\$ 0.06 million.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:

US\$ 0.07 million.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US\$ millions

– **Financial resources available to fund the decision in the current biennium:**

US\$ 0.06 million.

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

Not applicable.

– **Estimated financial 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. 2026–2027 cost of resources already planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.06	0.06
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.06	0.06
B.2.b. 2026–2027 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2028–2029 cost of resources to be planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.06	0.06
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.06	0.06
B.4. Future bienniums cost of resources to be planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.07	0.07
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.07	0.07
B.1. Total planned costs required to implement the decision									0.19

Decision EB158(2) Global action to advance health equity for people with haemophilia and other bleeding disorders

A. Link to the approved Programme budget 2026–2027

1. Output(s) in the approved Programme budget 2026–2027 under which this decision would be implemented:

2.2.1. WHO develops norms, standards and technical packages to address risk factors for communicable and noncommunicable diseases, violence and injuries, prevent poor nutrition, strengthen food safety and reduce environmental health risks, and supports countries in their implementation, including in the monitoring and development of legislation and regulations

3.1.3. WHO strengthens countries' national capacity to develop implementable national strategies for universal health coverage

4.1.1. WHO develops evidence-based policies and supports the implementation, scale-up and measurement of best buys and other actions to strengthen person-centred prevention, control and management of noncommunicable diseases

2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2026–2027:

Not applicable.

3. Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:

Not applicable.

4. Estimated time frame (in years or months) to implement the decision:

Three years (2026–2028).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. **Total planned costs required to implement the decision, in US\$ millions:**
US\$1.80 million.
- 2.a. **Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:**
US\$1.49 million.
- 2.b. **Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:**
Not applicable.
3. **Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:**
US\$ 0.31 million.
4. **Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:**
Not applicable.
5. **Level of financial resources already available to fund the implementation of the decision in the current biennium, in US\$ millions**
 - **Financial resources available to fund the decision in the current biennium:**
US\$ 0.50 million.
 - **Remaining financing gap in the current biennium:**
US\$ 0.99 million.
 - **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
Discussions are under way with potential donors.

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. 2026–2027 cost of resources already planned	Staff	0.13	0.14	0.10	0.13	0.10	0.10	0.42	1.12
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.37	0.37
	Total	0.13	0.14	0.10	0.13	0.10	0.10	0.78	1.49
B.2.b. 2026–2027 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2028–2029 cost of resources to be planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.31	0.31
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.31	0.31
B.4. Future bienniums cost of resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.1. Total planned costs required to implement the decision									1.80

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

Decision EB158(3) End TB Strategy

A. Link to the approved Programme budget 2026–2027

1. **Output(s) in the approved Programme budget 2026–2027 under which this decision would be implemented:**
 - 4.1.1. WHO develops evidence-based policies and supports the implementation, scale-up and measurement of best buys and other actions to strengthen person-centred prevention, control and management of noncommunicable diseases
 - 4.1.3. WHO provides leadership, develops evidence-based guidance and standards, and supports Member States to build capacity to deliver targeted, innovative and integrated people-centred services for communicable diseases
 - 4.1.4. WHO develops and disseminates guidance and tools to mitigate antimicrobial resistance, collects and reports data for action, raises awareness, guides research and innovation, builds country and regional capacity to implement a core package of interventions, and coordinates global multisectoral action
 - 4.3.1. WHO provides guidance and technical assistance and strengthens capacity to track and analyse health expenditures at the system level – to monitor financial hardship and financial barriers to access and inform decision-making for financial and social health protection
2. **Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**
Not applicable.
3. **Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:**
Not applicable.
4. **Estimated time frame (in years or months) to implement the decision:**
Two years (May 2026–May 2028).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. **Total planned costs required to implement the decision, in US\$ millions:**
US\$ 0.71 million. This refers to the workload required to develop a WHO post-2030 tuberculosis strategy. The workload related to preparing reports on ending tuberculosis for submission to the Eighty-first and Eighty-third World Health Assemblies was already included in the costing for resolution WHA73.3 (2020).
- 2.a. **Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:**
US\$ 0.71 million.
- 2.b. **Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:**
Not applicable.
3. **Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:**
Zero.
4. **Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:**
Zero.

5. **Level of financial resources already available to fund the implementation of the decision in the current biennium, in US\$ millions**
- **Financial resources available to fund the decision in the current biennium:**
US\$ 0.71 million.
 - **Remaining financing gap in the current biennium:**
Zero.
 - **Estimated financial 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. 2026–2027 cost of resources already planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.66	0.66
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.05	0.05
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.71	0.71
B.2.b. 2026–2027 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2028–2029 cost of resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.4. Future bienniums cost of resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.1. Total planned costs required to implement the decision									0.71

Decision EB158(4) Draft global strategy for integrated emergency, critical and operative care, 2026–2035

A. Link to the approved Programme budget 2026–2027

1. **Output(s) in the approved Programme budget 2026–2027 under which this decision would be implemented:**
- 3.1.1. WHO strengthens country capacity and provides guidance on the design, delivery, quality and measurement of integrated services
 - 3.1.2. WHO strengthens national institutional capacities for essential public health functions to improve health systems resilience
 - 3.1.3. WHO strengthens countries' national capacity to develop implementable national strategies for universal health coverage
 - 5.2.3. WHO provides technical expertise and operational support to strengthen and scale clinical care for emergencies, including infection prevention and control measures to protect health workers and patients
 - 6.2.2. WHO ensures the provision of life-saving care and maintains essential health services and systems in emergencies and vulnerable settings, addressing barriers to access and inequity

2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2026–2027:

Not applicable.

3. Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:

Not applicable.

4. Estimated time frame (in years or months) to implement the decision:

Ten years.

Pursuant to the decision's mandate, the strategy for 2026–2035 would be submitted for consideration by the Seventy-ninth World Health Assembly in May 2026, through the Executive Board at its 158th session, and subsequently translated into an action plan for execution through to 2035.

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US\$ millions:

US\$ 46.30 million.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:

US\$ 8.91 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:

Zero.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:

US\$ 9.48 million.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:

US\$ 27.91 million.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US\$ millions

– **Financial resources available to fund the decision in the current biennium:**

US\$ 4.00 million.

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

US\$ 4.91 million.

– **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**

Resource mobilization efforts are active and ongoing, including through the WHO Foundation with dedicated acute care fundraising efforts.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2026–2027 cost of resources already planned	Staff	0.29	0.28	0.24	0.28	0.22	0.24	0.36	1.91
	Activities	1.00	1.00	1.00	1.00	1.00	1.00	1.00	7.00
	Total	1.29	1.28	1.24	1.28	1.22	1.24	1.36	8.91
B.2.b. 2026–2027 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2028–2029 cost of resources to be planned	Staff	0.30	0.30	0.26	0.30	0.23	0.36	0.38	2.13
	Activities	1.05	1.05	1.05	1.05	1.05	1.05	1.05	7.35
	Total	1.35	1.35	1.31	1.35	1.28	1.41	1.43	9.48
B.4. Future bienniums cost of resources to be planned	Staff	0.93	0.92	0.79	0.91	0.71	0.78	1.17	6.21
	Activities	3.10	3.10	3.10	3.10	3.10	3.10	3.10	21.70
	Total	4.03	4.02	3.89	4.01	3.81	3.88	4.27	27.91
B.1. Total planned costs required to implement the decision									46.30

Decision EB158(5) Increasing availability, ethical access and oversight of transplantation of human cells, tissues and organs

A. Link to the approved Programme budget 2026–2027

- Output(s) in the approved Programme budget 2026–2027 under which this decision would be implemented:**
3.2.3. WHO supports countries to implement measures for better access to, and use of, safe, effective and quality-assured health products
- Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**
Not applicable.
- Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:**
Not applicable.
- Estimated time frame (in years or months) to implement the decision:**
One year.

B. Budget and resource implications for the Secretariat for implementation of the decision

- Total planned costs required to implement the decision, in US\$ millions:**
Zero. The submission of the strategy will be postponed by one year.
- 2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:**
Zero.

- 2.b. **Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:**
Not applicable.
3. **Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions**
Zero.
4. **Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:**
Zero.
5. **Level of financial resources already available to fund the implementation of the decision in the current biennium, in US\$ millions**
 - **Financial resources available to fund the decision in the current biennium:**
Not applicable.
 - **Remaining financing gap in the current biennium:**
Not applicable.
 - **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
Not applicable.

Decision EB158(6) Draft updated global action plan on antimicrobial resistance

A. Link to the approved Programme budget 2026–2027

1. **Output(s) in the approved Programme budget 2026–2027 under which this decision would be implemented:**
 - 4.1.4. WHO develops and disseminates guidance and tools to mitigate antimicrobial resistance, collects and reports data for action, raises awareness, guides research and innovation, builds country and regional capacity to implement a core package of interventions, and coordinates global multisectoral action
 - 5.1.2. WHO provides technical expertise and operational support to strengthen and scale preventive population and environmental public health interventions for all hazards, utilizing a One Health approach
2. **Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**
Not applicable.
3. **Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:**
Not applicable.
4. **Estimated time frame (in years or months) to implement the decision:**
Ten years (2026–2036).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. **Total planned costs required to implement the decision, in US\$ millions:**
US\$ 1.23 million.
This costing only addresses specific additional activities associated with multisectoral coordination and monitoring and evaluation of the global action plan. The planned resource requirements for WHO's contribution to supporting Member States in implementing accelerated action on antimicrobial resistance, as set out in the global action plan, were already costed under resolution WHA77.6 (2024) on antimicrobial resistance: accelerating national and global responses (total US\$ 503.25 million).

Decision EB158(7) WHO Global Code of Practice on the International Recruitment of Health Personnel

A. Link to the approved Programme budget 2026–2027

1. **Output(s) in the approved Programme budget 2026–2027 under which this decision would be implemented:**
3.2.1. WHO provides technical guidance and operational support to countries to optimize and expand their health and care workforce
2. **Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**
Not applicable.
3. **Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:**
Not applicable.
4. **Estimated time frame (in years or months) to implement the decision:**
Five months.

B. Budget and resource implications for the Secretariat for implementation of the decision

1. **Total planned costs required to implement the decision, in US\$ millions:**
Zero.
- 2.a. **Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:**
Zero.
- 2.b. **Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:**
Not applicable.
3. **Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:**
Zero.
4. **Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:**
Zero.
5. **Level of financial resources already available to fund the implementation of the decision in the current biennium, in US\$ millions**
 - **Financial resources available to fund the decision in the current biennium:**
Not applicable.
 - **Remaining financing gap in the current biennium:**
Not applicable.
 - **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
Not applicable.

Decision EB158(8) Economics of health for all

A. Link to the approved Programme budget 2026–2027

1. **Output(s) in the approved Programme budget 2026–2027 under which this decision would be implemented:**
3.2.2. WHO generates evidence, guides design and supports health-related macroeconomic policies and practices for sustainable health financing
2. **Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**
Not applicable.
3. **Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:**
Not applicable.
4. **Estimated time frame (in years or months) to implement the decision:**
Four years (2026–2030).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. **Total planned costs required to implement the decision, in US\$ millions:**
US\$ 15.29 million.
- 2.a. **Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:**
US\$ 5.94 million.
- 2.b. **Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:**
Not applicable.
3. **Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:**
US\$ 6.17 million.
4. **Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:**
US\$ 3.18 million.
5. **Level of financial resources already available to fund the implementation of the decision in the current biennium, in US\$ millions**
 - **Financial resources available to fund the decision in the current biennium:**
US\$ 0.62 million.
 - **Remaining financing gap in the current biennium:**
US\$ 5.32 million.
 - **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
Resource mobilization efforts are ongoing.

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. 2026–2027 cost of resources already planned	Staff	0.90	0.24	0.46	0.44	0.16	0.40	1.41	4.01
	Activities	0.44	0.13	0.17	0.45	0.05	0.28	0.41	1.93
	Total	1.34	0.37	0.62	0.90	0.21	0.67	1.82	5.94
B.2.b. 2026–2027 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2028–2029 cost of resources to be planned	Staff	0.94	0.24	0.47	0.46	0.17	0.41	1.47	4.17
	Activities	0.46	0.14	0.17	0.47	0.05	0.29	0.43	2.01
	Total	1.40	0.38	0.65	0.94	0.22	0.70	1.89	6.17
B.4. Future biennium cost of resources to be planned	Staff	0.48	0.13	0.24	0.24	0.09	0.21	0.76	2.15
	Activities	0.24	0.07	0.09	0.24	0.03	0.15	0.22	1.03
	Total	0.72	0.20	0.33	0.48	0.11	0.36	0.97	3.18
B.1. Total planned costs required to implement the decision									15.29

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

Decision EB158(9) Radiation and health: strengthening global protection, preparedness and response

A. Link to the approved Programme budget 2026–2027

- Output(s) in the approved Programme budget 2026–2027 under which this decision would be implemented:**
2.2.1. WHO develops norms, standards and technical packages to address risk factors for communicable and noncommunicable diseases, violence and injuries, prevent poor nutrition and strengthen food safety and reduce environmental health risks, and supports countries in their implementation, including in the monitoring and development of legislation and regulations
- Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**
Not applicable.
- Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:**
Not applicable.
- Estimated time frame (in years or months) to implement the decision:**
Two and a half years.

Decision EB158(10) Draft global action plan for the health of Indigenous Peoples

A. Link to the approved Programme budget 2026–2027

1. **Output(s) in the approved Programme budget 2026–2027 under which this decision would be implemented:**
 - 3.1.3. WHO strengthens countries' national capacity to develop implementable national strategies for universal health coverage
 - 7.1.1. Convening, advocating and engagement with Member States and key constituencies in support of health governance and to advance health priorities
2. **Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**
Not applicable.
3. **Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:**
Not applicable.
4. **Estimated time frame (in years or months) to implement the decision:**
Sixteen months (January 2026–May 2027).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. **Total planned costs required to implement the decision, in US\$ millions:**
US\$ 1.36 million. This does not represent an additional cost but rather a share of the originally planned cost under resolution WHA76.16 (2023) (US\$ 6.68 million until May 2026). The planned amount already included the remaining consultations; therefore, the US\$ 1.36 million reflects the portion of the original US\$ 6.68 million that will now be incurred during the extended period through mid-2027.
- 2.a. **Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:**
US\$ 1.36 million.
- 2.b. **Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:**
Not applicable.
3. **Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:**
Not applicable.
4. **Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:**
Not applicable.
5. **Level of financial resources already available to fund the implementation of the decision in the current biennium, in US\$ millions**
 - **Financial resources available to fund the decision in the current biennium:**
US\$ 0.86 million.
 - **Remaining financing gap in the current biennium:**
US\$ 0.50 million.
 - **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
Fundraising efforts are ongoing, and discussions are under way to secure potential donor support to cover the gap.

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. 2026–2027 cost of resources already planned	Staff	0.06	0.06	0.05	0.06	0.05	0.05	0.53	0.86
	Activities	0.02	0.02	0.02	0.02	0.02	0.02	0.38	0.50
	Total	0.08	0.08	0.07	0.08	0.07	0.07	0.91	1.36
B.2.b. 2026–2027 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2028–2029 cost of resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.4. Future bienniums cost of resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.1. Total planned costs required to implement the decision									1.36

Decision EB158(11) Evaluation: workplan for 2026–2027**A. Link to the approved Programme budget 2026–2027**

- Output(s) in the approved Programme budget 2026–2027 under which this decision would be implemented:**
8.1.3 Accountability and legal functions enhanced in a transparent, compliant and risk management-driven manner, promoting Organizational learning, effective internal justice, safety and impact at the country level
- Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**
Not applicable.
- Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:**
Not applicable.
- Estimated time frame (in years or months) to implement the decision:**
Twenty-four months.

B. Budget and resource implications for the Secretariat for implementation of the decision

- Total planned costs required to implement the decision, in US\$ millions:**
US\$ 12.86 million.
- 2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:**
US\$ 12.86 million.

- 2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:**
Not applicable.
- 3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:**
Not applicable.
- 4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:**
Not applicable.
- 5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US\$ millions**
- **Financial resources available to fund the decision in the current biennium:**
US\$ 9.84 million.
 - **Remaining financing gap in the current biennium:**
US\$ 3.02 million.
 - **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
Resource mobilization efforts are ongoing, including integration of evaluation into larger donors proposals and grant agreements, in order to enable implementation of the planned evaluations in the Organization.

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. 2026–2027 cost of resources already planned	Staff	0.72	1.04	0.51	0.64	0.54	0.51	4.30	8.27
	Activities	0.33	0.36	0.76	0.36	0.79	0.31	1.70	4.59
	Total	1.05	1.40	1.27	1.00	1.33	0.82	6.00	12.86
B.2.b. 2026–2027 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2028–2029 cost of resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.4. Future bienniums cost of resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.1. Total planned costs required to implement the decision									12.86

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

Decision EB158(12) Withdrawal of the Argentine Republic from the World Health Organization

A. Link to the approved Programme budget 2026–2027

1. **Output(s) in the approved Programme budget 2026–2027 under which this decision would be implemented:**
7.1.1. Convening, advocating and engagement with Member States and key constituencies in support of health governance and to advance health priorities
2. **Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**
Not applicable.
3. **Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:**
Not applicable.
4. **Estimated time frame (in years or months) to implement the decision:**
The decision would take place with immediate effect but the default value used here is one year.

B. Budget and resource implications for the Secretariat for implementation of the decision

1. **Total planned costs required to implement the decision, in US\$ millions:**
Not applicable.¹
- 2.a. **Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:**
Not applicable.
- 2.b. **Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:**
Not applicable.
3. **Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:**
Not applicable.
4. **Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:**
Not applicable.
5. **Level of financial resources already available to fund the implementation of the decision in the current biennium, in US\$ millions**
 - **Financial resources available to fund the decision in the current biennium:**
Not applicable.
 - **Remaining financing gap in the current biennium:**
Not applicable.
 - **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
Not applicable.

¹ The costing of this decision does not address the direct or indirect costs required by the Secretariat to implement deliverables as the decision text does not specify any such deliverables. The possibility of broader, financial implications of this decision for the Organization may require further consideration within the framework of WHO's governing bodies.

Decision EB158(13) Administration of public health prizes and awards

A. Link to the approved Programme budget 2026–2027

1. **Output(s) in the approved Programme budget 2026–2027 under which this decision would be implemented:**
7.1.1. Convening, advocating and engagement with Member States and key constituencies in support of health governance and to advance health priorities
2. **Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**
Not applicable.
3. **Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:**
Not applicable.
4. **Estimated time frame (in years or months) to implement the decision:**
Until 2031.

The recommendations shall be reviewed and decided upon by the prize selection panels respectively in 2027 and 2028, approved by the Executive Board in the same year, and implemented in 2029 at the earliest. One-off outputs include: adjusting the allocation mechanism for the elective posts; developing the digital platform; initiating a sustainable financing mechanism; and revising the prize statutes, drafting guidelines and seeking Executive Board approval to reflect these streamlining and cost recovery measures. Recurring activities (implementation of the sustainable financing mechanism, maintenance of the digital platform) will become part of the administration of the prizes and are costed until 2031.

B. Budget and resource implications for the Secretariat for implementation of the decision

1. **Total planned costs required to implement the decision, in US\$ millions:**
US\$ 0.13 million.
- 2.a. **Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:**
US\$ 0.07 million.
- 2.b. **Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:**
Not applicable.
3. **Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:**
US\$ 0.03 million.
4. **Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:**
US\$ 0.03 million.
5. **Level of financial resources already available to fund the implementation of the decision in the current biennium, in US\$ millions**
 - **Financial resources available to fund the decision in the current biennium:**
US\$ 0.02 million.
 - **Remaining financing gap in the current biennium:**
US\$ 0.05 million.

- **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**

Efforts are being made to ensure sustainable financing of the public health prizes and awards by requesting a contribution from the prize founder each time that the prize is awarded so as to cover activity costs. Furthermore, efforts are under way to raise funds to fund digital solutions for the WHO governing bodies, which will enable the digitalization of the application and selection process.

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. 2026–2027 cost of resources already planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.03	0.03
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.04	0.04
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.07	0.07
B.2.b. 2026–2027 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2028–2029 cost of resources to be planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.01
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.02	0.02
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.03	0.03
B.4. Future bienniums cost of resources to be planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.01
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.02	0.02
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.03	0.03
B.1. Total planned costs required to implement the decision									0.13

Decision EB158(19) Proposed amendments to the process for the selection of the External Auditor

A. Link to the approved Programme budget 2026–2027

- Output(s) in the approved Programme budget 2026–2027 under which this decision would be implemented:**
8.1.6. Sound financial practices supported by an effective internal control framework to ensure transparency, accountability, and optimal financial management
- Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**
Not applicable.
- Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:**
Not applicable.
- Estimated time frame (in years or months) to implement the decision:**
There is no defined end date.

B. Budget and resource implications for the Secretariat for implementation of the decision

1. **Total planned costs required to implement the decision, in US\$ millions:**
Zero.
- 2.a. **Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:**
Zero.
- 2.b. **Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:**
Not applicable.
3. **Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:**
Zero.
4. **Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:**
Zero.
5. **Level of financial resources already available to fund the implementation of the decision in the current biennium, in US\$ millions**
 - **Financial resources available to fund the decision in the current biennium:**
Not applicable.
 - **Remaining financing gap in the current biennium:**
Not applicable.
 - **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
Not applicable.

Decision EB158(21) Member State-led governance reform**Decision EB158(22) Sustainable model for Member State-led governance reform****A. Link to the approved Programme budget 2026–2027**

1. **Output(s) in the approved Programme budget 2026–2027 under which these decisions would be implemented:**
7.1.1. Convening, advocating and engagement with Member States and key constituencies in support of health governance and to advance health priorities
2. **Short justification for considering the decisions, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**
Not applicable.
3. **Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:**
The decisions suggested by Members States and the Officers of the Executive Board, as part of the discussions on the WHO governance reform, have not been planned for in the existing workplans of the Governing Bodies department. A new advisory group is suggested, which did not exist before and will require support by the Governing Bodies department. In addition, a new process is being proposed for the Secretariat to develop strengthened criteria to improve the quality of draft resolutions and decisions, which will require not only one-off developmental work but also ongoing analytical work as resolutions and decisions are being put forward. This has so far not been planned in the Governing Bodies department. While the budget of the department will need to be reviewed, the costs related to these decisions can, however, be accommodated within the overall organizational budget.

4. Estimated time frame (in years or months) to implement the decisions:

The decisions do not contain defined timelines. The next reporting date is proposed for the Executive Board at its 160th session; however, with the implicit expectation that the group continues its work beyond that date.

B. Budget and resource implications for the Secretariat for implementation of the decisions

1. Total planned costs required to implement the decisions, in US\$ millions:

US\$ 1.65 million.

The total planned costs required to implement the two decisions will mainly depend on the frequency of the interactions/meetings of the advisory group, its duration, as well as the support needed for the new processes. Assuming the need for support, the frequency of interactions and that it will continue over several bienniums, the total planned costs are around US\$ 1.65 million. This is composed of salary costs for facilitating the mechanism as well as some activity costs to support meetings.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:

US\$ 0.55 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:

Zero.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:

US\$ 0.55 million.

This amount is calculated on the assumption that the mechanisms continue beyond the end of the biennium 2026–2027.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:

US\$ 0.55 million.

This amount is calculated on the assumption that the mechanisms continue beyond the end of the current biennium.

5. Level of financial resources already available to fund the implementation of the decisions in the current biennium, in US\$ millions

– **Financial resources available to fund the decisions in the current biennium:**

Zero.

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

Funding for the full estimated costs of US\$ 1.65 million for the implementation of these decisions is yet to be identified.

– **Estimated financial 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. 2026–2027 cost of resources already planned (not yet allocated to the budget space of the relevant department)	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.50	0.50
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.05	0.05
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.55	0.55
B.2.b. 2026–2027 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2028–2029 cost of resources to be planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.50	0.50
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.05	0.05
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.55	0.55
B.4. Future bienniums cost of resources to be planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.50	0.50
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.05	0.05
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.55	0.55
B.1. Total planned costs required to implement the decisions									1.65

Decision EB158(23) Engagement with non-State actors**A. Link to the approved Programme budget 2026–2027**

- Output(s) in the approved Programme budget 2026–2027 under which this decision would be implemented:**
8.1.3. Accountability and legal functions enhanced in a transparent, compliant and risk management-driven manner, promoting Organizational learning, effective internal justice, safety and impact at country level
- Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**
Not applicable.
- Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:**
Not applicable.
- Estimated time frame (in years or months) to implement the decision:**
Official relations with non-State actors is a standing agenda item of the Executive Board.

B. Budget and resource implications for the Secretariat for implementation of the decision

- Total planned costs required to implement the decision, in US\$ millions:**
Resources associated with interactions with non-State actors in official relations are part of the regular planning cycle and are not calculated separately.

- 2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:**
Not applicable.
- 2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:**
Not applicable.
- 3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:**
Not applicable.
- 4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:**
Not applicable.
- 5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US\$ millions**
- **Financial resources available to fund the decision in the current biennium:**
Not applicable.
 - **Remaining financing gap in the current biennium:**
Not applicable.
 - **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
Not applicable.
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