



WORLD HEALTH ORGANIZATION

SEVENTY-FOURTH WORLD HEALTH ASSEMBLY

GENEVA, 24 MAY – 1 JUNE 2021

**RESOLUTIONS AND DECISIONS
ANNEXES**

**GENEVA
2021**

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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

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

PREFACE

The Seventy-fourth World Health Assembly was held virtually, using video conference technology and coordinated from WHO headquarters, Geneva, from 24 May to 1 June 2021, in accordance with the decision of the Executive Board at its 147th session.¹

¹ Decision EB147(7) (2020).

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- C. Promoting the health of refugees and migrants (decision WHA72(14) (2019))
- D. Eradication of dracunculiasis (resolution WHA64.16 (2011))
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- F. ¹

¹ Moved as document A74/55 under item 26.4.

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- G. Smallpox eradication: destruction of variola virus stocks (resolution WHA60.1 (2007))

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² See Annex 3.

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A74/10 Add.3	Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases Options paper on the global coordination mechanism on the prevention and control of noncommunicable diseases
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¹ See Annex 4.

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¹ See Annex 4.

² See Annex 1.

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A74/INF./2	COVID-19 response Main report of the Independent Panel for Pandemic Preparedness and Response
A74/INF./3	WHO reform WHO presence in countries, territories and areas: 2021 report
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OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES¹

President

Ms Dechen WANGMO (Bhutan)

Vice-Presidents

Professor Benjamin HOUNKPATIN (Benin)

Mr Enkhbold SEREEJAV (Mongolia)

Dr Hanan M. AL-KUWARI (Qatar)

Mr Tanel KIIK (Estonia)

Dr Amelia FLORES (Guatemala)

Secretary

Dr Tedros Adhanom GHEBREYESUS,
Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Andorra, Australia, Cameroon, Haiti, Iceland, Mali, Monaco, Namibia, Panama, Singapore, Somalia and Thailand.

Chair: H.E. Ms Carole LANTERI (Monaco)

Vice-Chair: Dr Mohamed JAMA (Somalia)

Secretary: Mr Xavier DANAY, Senior Legal Officer

General Committee

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the Chairs of the main committees, together with the delegates of the following Member States: Algeria, Burundi, Canada, Chile, China, Cuba, Djibouti, France, Oman, Philippines, Portugal, Russian Federation, Sri Lanka, United Kingdom of Great Britain and Northern Ireland, United States of America, Zambia and Zimbabwe.

Chair: Ms Dechen WANGMO (Bhutan)

Secretary: Dr Tedros Adhanom
GHEBREYESUS, Director-General

MAIN COMMITTEES

Under Rule 34 of the Rules of Procedure of the World Health Assembly, each delegation is entitled to be represented on each main committee by one of its members.

Committee A

Chair: Dr Adriana AMARILLA (Paraguay)

Vice-Chairs: Dr Zwelini MKHIZE (South Africa)

Dr Ali Muhammad Miftah AL-ZINATI
(Libya)

Rapporteur: Professor Plamen DIMITROV
(Bulgaria)

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

Committee B

Chair: Dr Ifereimi WAQAINABETE (Fiji)

Vice-Chairs: Dr Søren BROSTRØM (Denmark)

Ms Kazi Zebunnessa BEGUM (Bangladesh)
H.E. Mr Md. Mustafizur RAHMAN
(Bangladesh) ad interim

Rapporteur: Lt. Col. Jeffrey BOSTIC (Barbados)

Secretary: Ms Ivana MILOVANOVIC, Senior
Policy Lead, Office of the Director-General's
Envoy for Multilateral Affairs

REPRESENTATIVES OF THE EXECUTIVE BOARD

Dr Harsh VARDHAN (India)

Dr Ahmed Mohammed AL SAIDI (Oman)

Dr Patrick AMOTH (Kenya)

Mr Björn KÜMMEL (Germany)

¹ In addition, the list of delegates and other participants is contained in document A74/DIV./1 Rev.1.

RESOLUTIONS AND DECISIONS

RESOLUTIONS

WHA74.1 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution

The Seventy-fourth World Health Assembly,

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

Noting that Chad, the Democratic Republic of the Congo, Equatorial Guinea, Sudan, Suriname and Yemen were in arrears at the time of the opening of the Seventy-fourth World Health Assembly to such an extent that it was necessary for the Health Assembly to consider, in accordance with Article 7 of the Constitution, whether the voting privileges of those countries should be suspended at the opening of the Seventy-fourth World Health Assembly in 2021,

DECIDES:

(1) that since at the time of the opening of the Seventy-fourth World Health Assembly, Chad, the Democratic Republic of the Congo, Equatorial Guinea, Sudan, Suriname and Yemen were still in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution, their voting privileges shall be suspended as from the time that this resolution is adopted;

(2) that the suspension that takes effect as set out in paragraph (1) above shall continue at the Seventy-fifth World Health Assembly and subsequent Health Assemblies, until the arrears of Chad, the Democratic Republic of the Congo, Equatorial Guinea, Sudan, Suriname and Yemen have been reduced to a level below the amount that would justify invoking Article 7 of the Constitution;

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

(Second plenary meeting, 24 May 2021)

WHA74.2 Admission of the Faroe Islands as an Associate Member

The Seventy-fourth World Health Assembly,

Having considered the application from the Government of Denmark on behalf of the Faroe Islands for admission of the Faroe Islands to associate membership of the World Health Organization,²

¹ Document A74/30.

² Document A74/4; see also documents A74/INF./5 and A74/33.

ADMITS the Faroe Islands as an Associate Member of the World Health Organization, subject to notice being given of acceptance of associate membership on behalf of the Faroe Islands in accordance with Rules 117 and 118 of the Rules of Procedure of the World Health Assembly.

(Fifth plenary meeting, 26 May 2021)

WHA74.3 Programme budget 2022–2023

The Seventy-fourth World Health Assembly,

Having considered the Proposed programme budget 2022–2023;¹

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

Noting that the Proposed programme budget 2022–2023 is the second programme budget to be prepared in line with the Thirteenth General Programme of Work, 2019–2023 and WHO's triple billion strategic priority approach;

Recognizing that the Proposed programme budget 2022–2023 presents a priority setting for WHO with an emphasis on four key areas of strategic focus to be achieved at all three levels of the Organization;

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

Re-emphasizing the necessity to ensure a strong WHO that will undertake the global leadership role in public health, taking into account the lessons learned from the coronavirus disease (COVID-19) pandemic, with respect to work that must be carried out under all circumstances to meet WHO's objective: the attainment by all peoples of the highest possible level of health;

Welcoming the increase in both the absolute level and the proportionate share of the budget at the country level to develop further the impact, capacity and integrated systems at that level;

Stressing the continued importance of investment in the normative functions of the Organization;

Aware of the continued incorporation of emergency operations and appeals as a costed element in the Proposed programme budget 2022–2023;

Further welcoming the strengthening of transparency, accountability and compliance functions, as well as opportunities for efficiency savings across all of WHO, and recognizing the importance of allocating adequate and sustainable funds equitably for enabling functions across all major offices;

Reaffirming WHO's full and continued commitment to and engagement in the implementation of United Nations development system reform, and its ongoing work to support countries in their efforts to reach all health-related Sustainable Development Goal targets;

Welcoming the efforts to mainstream essential public health functions currently performed by the polio programme and emphasizing that poliovirus remains a public health emergency of international

¹ Document A74/5 Rev.1.

² Document A74/46.

concern and full eradication of all polioviruses must be secured as WHO gradually shifts functions from the polio eradication segment of the programme budget into the relevant outcomes of the base programme budget;

Stressing that proposed increases above the level of the approved Programme budget 2022–2023 should be requested only when necessary for the purpose of the Organization's mandated activities and after all possible steps have been taken to finance such increases through savings, global efficiencies and prioritization,

1. APPROVES the programme of work, as outlined in the Proposed programme budget 2022–2023, noting also the background information on its operationalization;
2. FURTHER APPROVES the budget for the financial period 2022–2023, under all sources of funds, namely, assessed and voluntary contributions of US\$ 6121.7 million;
3. ALLOCATES the budget for the financial period 2022–2023 to the following strategic priorities and other areas:

Strategic priorities:

- (1) One billion more people benefiting from universal health coverage, US\$ 1839.9 million;
- (2) One billion more people better protected from health emergencies, US\$ 845.9 million;
- (3) One billion more people enjoying better health and well-being, US\$ 424.9 million;
- (4) More effective and efficient WHO providing better support to countries, US\$ 1253.3 million (including financing the United Nations Resident Coordinator system in accordance with relevant resolutions of the United Nations General Assembly);

Other areas:

- Polio eradication (US\$ 558.3 million), special programmes (US\$ 199.3 million) totalling US\$ 757.6 million;
- Emergency operations and appeals (US\$ 1000.0 million), which, being subject to the event-driven nature of the activities concerned, is an estimated budget requirement that can be subject to increase as necessary;

4. RESOLVES that the budget will be financed as follows:
 - by net assessments on Member States adjusted for estimated Member State non-assessed income, for a total of US\$ 956.9 million;
 - from voluntary contributions, for a total of US\$ 5164.8 million;
5. FURTHER RESOLVES that the gross amount of the assessed contribution for each Member State shall be reduced by the sum standing to their credit in the Tax Equalization Fund; that this reduction shall be adjusted in the case of those Members that require staff members to pay income taxes on their WHO emoluments, taxes which the Organization reimburses to the said staff members; and that the amount of such tax reimbursements is estimated at US\$ 8.0 million, resulting in a total assessment on Members of US\$ 964.9 million;

6. DECIDES that the Working Capital Fund shall be maintained at its existing level of US\$ 31.0 million;
7. AUTHORIZES the Director-General to use the assessed contributions together with the voluntary contributions, subject to the availability of resources, to finance the budget as allocated in paragraph 3, up to the amounts approved;
8. FURTHER AUTHORIZES the Director-General, where necessary, to make budget transfers among the four strategic priorities, up to an amount not exceeding 5% of the amount allocated to the strategic priority from which the transfer is made. Any such transfers will be reported in the statutory reports to the respective governing bodies;
9. FURTHER AUTHORIZES the Director-General, where necessary, to incur additional expenditures in the emergency operations and appeals area, subject to availability of resources;
10. FURTHER AUTHORIZES the Director-General, where necessary, to incur expenditures in the special programmes and polio eradication components of the budget beyond the amount allocated for these components, as a result of additional governance and resource mobilization mechanisms, as well as their budget cycle, which inform the annual and/or biennial budgets for these special programmes, subject to availability of resources;
11. REQUESTS the Director-General:
 - (1) to submit regular reports on the financing and implementation of the budget as presented in document A74/5 Rev.1, and outlook on the financing of the Organization and the results of the coordinated resource mobilization strategy to the Health Assembly, through the Executive Board and its Programme, Budget and Administration Committee;
 - (2) to submit annual reports on the progress of the results framework of the Thirteenth General Programme of Work, 2019–2023 broken down for all three levels of WHO including contribution of the Secretariat towards the achievement of programmatic outcomes and impacts, measured through an assessment of the delivery of the 42 outputs articulated in the Programme budget 2022–2023;
 - (3) to control costs and seek efficiencies across all of WHO, and to submit regular reports to the Executive Board and its Programme, Budget and Administration Committee with detailed information on these savings and global efficiencies as well as an estimation of savings achieved;
 - (4) to submit, as deemed necessary, a revised Programme budget 2022–2023, including its revised appropriation resolution, as appropriate, to the Seventy-fifth World Health Assembly in 2022 to reflect the rapidly changing health situation of the world due to the COVID-19 pandemic, in the light of the findings of the independent reviews presented to the Seventy-fourth World Health Assembly and the recommendations of the Working Group on Sustainable Financing;

(5) to submit to the Seventy-fifth World Health Assembly in 2022, through the 150th session of the Executive Board, a draft resolution on extending the Thirteenth General Programme of Work, 2019–2023, until 2025, and its possible revisions and updates.

(Seventh plenary meeting, 31 May 2021 –
Committee A, first report)

WHA74.4 Reducing the burden of noncommunicable diseases through strengthening prevention and control of diabetes¹

The Seventy-fourth World Health Assembly,

Having considered the consolidated report by the Director-General;²

Recalling WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2030 and the following five voluntary global diabetes-related targets for 2025: a 25% relative reduction in the overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases; halt the rise in diabetes and obesity; at least 50% of eligible people receive medicinal treatment (including glycaemic control) and counselling to prevent heart attacks and strokes; an 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases (including diabetes) in both public and private facilities; and a 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years;

Recalling also the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases (United Nations General Assembly resolution 66/2 (2011), which recognizes the primary role and responsibility of Governments in responding to the challenge of noncommunicable diseases by developing adequate national multisectoral responses for their prevention and control;

Also recalling resolution WHA66.10 (2013) on the endorsement of WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2020 and decision WHA72(11) (2019), which extended the global action plan until 2030;

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

Recalling United Nations General Assembly resolution 70/1 (2015), which adopted the 2030 Agenda for Sustainable Development and defined the Sustainable Development Goals, as well as the associated target 3.4 of reducing the risk of premature mortality from diabetes and other major noncommunicable diseases by one third by 2030;

Having considered Annex 11 to the report of the Director-General in document A74/10 Rev.1 on major obstacles to achieving the diabetes-related targets in the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2030, including that halting the rising prevalence of diabetes, and reducing its impact, will not happen unless the five diabetes-related targets are achieved, including through reducing obesity;

Reaffirming our commitment in United Nations General Assembly resolution 74/2 (2019) to progressively cover 1 billion additional people by 2023 with quality essential health services and quality,

¹ See Annex 4 for the financial and administrative implications for the Secretariat of this resolution.

² Document A74/10 Rev.1.

safe, effective, affordable and essential medicines, vaccines, diagnostics and health technologies, with a view to achieving universal health coverage by 2030;

Noting that more than 420 million people are living with diabetes worldwide today, and that this number is estimated to rise to 578 million by 2030, and 700 million by 2045;¹

Noting that the increasing number of people living with diabetes is strongly associated with insufficient prevention of risk factors that underly diabetes, such as overweight and obesity, unhealthy diets, physical inactivity and tobacco use, and related to socioeconomic status and the impact of the social, economic and environmental determinants of health;

Highlighting also the commitment made to promote and implement policy, legislative and regulatory measures, including fiscal measures as appropriate, aiming at minimizing the impact of the main risk factors for diabetes, and to promote healthy diets and lifestyles;

Concerned that the number of people living with diabetes is increasing when at the same time some types of diabetes can be largely prevented with healthy diets and physical activity;

Aware that one in two adults living with diabetes type 2 are undiagnosed, and that four out of five adults living with diabetes live in low- and middle-income countries;

Deeply concerned that, while the probability (risk) of premature death from any one of the four main noncommunicable diseases decreased by 18% globally between 2000 and 2016, diabetes is showing, for the first time ever, a 5% increase in premature mortality during the same period;²

Noting with concern that, in high-income countries, the premature mortality rate due to diabetes increased in 2010–2016, following a decrease from 2000 to 2010, and that in low- and middle-income countries, the premature mortality rate due to diabetes increased across both periods;²

Concerned that people living with noncommunicable diseases, including diabetes, have a higher risk of becoming severely ill or dying from coronavirus disease (COVID-19), and are among those most impacted by the COVID-19 pandemic;³

Concerned also that complete or partial disruptions to diabetes prevention and control due to the COVID-19 pandemic, including in respect of early detection and diabetic complication management services, represent significant threats to the life and health of people living with diabetes;

Noting that overweight and obesity with metabolic changes and hypertension can increase the risk of noncommunicable diseases, such as diabetes and other cardiovascular diseases;

Reaffirming that universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative, rehabilitative and palliative essential timely measures and health services, promotion of lifestyle changes, healthy and balanced diets and regular physical activity and essential, safe, affordable, effective and quality medicines and vaccines, while ensuring that the use of these services does not expose the

¹ See document A74/10 Rev.1.

² World health statistics 2020: monitoring health for the SDGs, sustainable development goals. Geneva: World Health Organization; 2020:12 (<https://apps.who.int/iris/handle/10665/332070>, accessed 23 May 2021).

³ In accordance with paragraph 9 of United Nations General Assembly resolution 74/306 (2020).

users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population;¹

Reaffirming also our commitment in United Nations General Assembly resolution 73/2 (2018) to further strengthen efforts to address diabetes as part of universal health coverage through intensified interventions at the primary health care level, including in low- and middle-income countries, on prevention and control of diabetes;

Emphasizing the importance of prevention and control of diabetes over the life course, especially among children and adolescents and their families, through reducing major risk factors, including unhealthy diets and physical inactivity, as well as raising awareness of and reducing the impact of the main risk factors and recognizing that early detection of diabetes offers an opportunity for timely initiation of treatment to improve health and well-being and reduce morbidity, disability and mortality;

Recognizing the role of insulin in the treatment of type 1 diabetes and of type 2 diabetes resistant to lifestyle changes and other drug therapies;

Noting that, out of 420 million people living with diabetes, all require appropriate diabetes management, and an estimated nine million people with type 1 diabetes require insulin to survive and around 60 million people with type 2 diabetes require insulin to manage their condition; and further noting that the need for insulin required to treat type 2 diabetes is expected to increase by more than 20% by 2030;

Recognizing that insulin is an essential life-saving medicine, but deeply concerned that despite being discovered 100 years ago in 1921, globally about half of the people in need of insulin have no or irregular access, with unacceptable inequities between and within countries;

Concerned that insulin is largely unaffordable for people paying out-of-pocket and that its high prices are a burden for national health systems, and noting the significant role that mark-ups along the value chain may play in pricing for patients and health systems;

Recognizing the importance of international cooperation in support of national, regional and global plans for the prevention and control of diabetes, including to increase access to treatment such as insulin, with a view to reducing the negative socioeconomic impact of diabetes that significantly affects the quality of life of persons with diabetes and their families in every country, especially in developing countries;

Noting with appreciation the WHO Global Diabetes Compact initiative – launched on 14 April 2021 during the Global Diabetes Summit, co-hosted by WHO and the Government of Canada, with the support of the University of Toronto – which aims to reduce the risk of diabetes, and ensure that all people who are diagnosed with diabetes have access to equitable, comprehensive, affordable and quality treatment and care,

1. URGES Member States:²

- (1) to apply whole-of-government and whole-of-society approaches that place achievement of the five diabetes- and obesity-related global voluntary targets at the centre of the response;

¹ In accordance with paragraph 9 of United Nations General Assembly resolution 74/2 (2019).

² And, where applicable, regional economic integration organizations.

- (2) to raise, within national noncommunicable disease responses, the priority given to the prevention and control of diabetes, including management of obesity, early diagnosis, treatment, care and management of complications, taking into account national priorities;
- (3) to strengthen policy, legislative and regulatory measures, including fiscal measures as appropriate, aiming at minimizing the impact of the main risk factors for diabetes and promoting healthy diets and lifestyles;
- (4) to raise awareness about the national public health burden caused by diabetes, through a life course perspective, and about the relationship between diabetes, poverty and social and economic development, as well as the relationship between obesity and risk for developing type 2 diabetes;
- (5) to ensure a continued focus on maintaining a high level of treatment and care for all people, regardless of the COVID-19 pandemic, including for people living with diabetes, especially in low- and middle-income countries, recognizing that necessary diabetes prevention and control efforts are hampered by, inter alia, lack of universal access to quality, safe, effective, affordable essential health services, medicines, diagnostics and health technologies, as well as by a global shortage of qualified health workers;
- (6) to ensure that national strategies for the prevention and control of noncommunicable diseases contain the necessary provisions to cover persons living with diabetes with quality essential health services and promote access to diagnostics and quality, safe, effective, affordable and essential medicines, including insulin, oral hypoglycaemic agents and other diabetes-related medicines and health technologies for all people living with diabetes, in accordance with national context and priorities;
- (7) to strengthen health systems and high-quality, integrated and people-centred primary health services for all, health management information systems, and an adequate and well-trained and equipped health workforce, taking into account national contexts;
- (8) to improve prevention and control of diabetes throughout the life course through the reduction of modifiable and preventable risk factors for diabetes, including obesity and physical inactivity, and better access to safe, affordable, effective and quality essential diagnostics, medicines and other related health products;
- (9) to strengthen health promotion and improve health literacy, including through access to understandable and high-quality, patient-friendly information and education;
- (10) to strengthen monitoring and evaluation of diabetes responses, through country-level surveillance and monitoring systems, including surveys, that are integrated into existing national health information systems, and by identifying priority areas for diabetes research;
- (11) to continue working collaboratively, in accordance with national and regional legal frameworks and contexts, to improve the reporting of information by suppliers on registered diabetes medicines and other related health products;

2. REQUESTS the Director-General:

- (1) to develop, in collaboration with Member States,¹ and in consultation with non-State actors and people living with or affected by diabetes, recommendations to strengthen and monitor diabetes responses within national noncommunicable disease programmes, and recommendations for the prevention and management of obesity over the life course, including considering the potential development of targets in this regard, and to submit these recommendations to the Seventy-fifth World Health Assembly for its consideration in 2022, through the Executive Board at its 150th session;
- (2) to develop pathways of how to achieve the targets for the prevention and control of diabetes, including access to insulin, throughout the life course within national noncommunicable disease responses to achieve Sustainable Development Goal target 3.4, and including providing support for strengthening diabetes monitoring and surveillance;
- (3) to provide concrete guidance to Member States, especially in low-income countries, on strengthening design and implementation of policies for diabetes prevention and control across all relevant sectors, including that for resilient health systems and health services and infrastructure;
- (4) to provide concrete guidance to Member States for uninterrupted treatment of people living with diabetes in humanitarian emergencies;
- (5) to promote convergence and harmonization of regulatory requirements for diabetes medicines, including insulin, biosimilars and other related health products that facilitate availability of and access to safe and effective and quality-assured products, meeting standards set by WHO and competent authorities;
- (6) to continue to analyse the availability of data on inputs throughout the value chain, including data on clinical trials and price information, with a view to assessing the feasibility and potential value of establishing a web-based tool to share information relevant to the transparency of markets for diabetes medicines, including insulin, oral hypoglycaemic agents and related health products, including information on investments, incentives and subsidies;
- (7) to develop recommendations for adequate, predictable and sustained financing of diabetes prevention and control, including in resource-constrained settings, and to address the needs of disadvantaged and marginalized populations;
- (8) to report on progress made in the implementation of the present resolution to the Health Assembly as part of the consolidated reporting on the progress achieved in the prevention and control of noncommunicable diseases, with an annual report to be submitted to the Health Assembly through the Executive Board, from 2022 to 2031.²

(Seventh plenary meeting, 31 May 2021 –
Committee A, first report)

¹ And, where applicable, regional economic integration organizations.

² In accordance with paragraph 3(e) of decision WHA72(11) (2019).

WHA74.5 Oral health¹

The Seventy-fourth World Health Assembly,

Having considered the consolidated report by the Director-General;²

Recalling resolutions WHA60.17 (2007) on oral health: action plan for promotion and integrated disease prevention, WHA69.3 (2016) on the global strategy and action plan on ageing and health 2016–2020: towards a world in which everyone can live a long and healthy life, WHA72.2 (2019) on primary health care; and decisions 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 and WHA73(12) (2020) on the Decade of Healthy Ageing 2020–2030;

Mindful of the 2030 Agenda for Sustainable Development, in particular Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages), and recognizing the important intersections between oral health and other Sustainable Development Goals, including Goal 1 (End poverty in all its forms and everywhere), Goal 2 (End hunger, achieve food security and improved nutrition and promote sustainable agriculture), Goal 4 (Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all) and Goal 12 (Ensure sustainable consumption and production patterns);

Recalling the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (2011), recognizing that oral diseases pose a major challenge and could benefit from common responses to noncommunicable diseases;

Recalling also the political declaration of the high-level meeting on universal health coverage (2019), including the commitment therein to strengthen efforts to address oral health as part of universal health coverage;

Mindful of the Minamata Convention on Mercury (2013), a global treaty to protect human health and the environment from anthropogenic emissions and releases of mercury and mercury compounds, calling for phase-down of the use of dental amalgam taking into account domestic circumstances and relevant international guidance; and recognizing that a viable replacement material should be developed through focused research;

Recognizing that oral diseases are highly prevalent, with more than 3.5 billion people affected by them, and that oral diseases are closely linked to noncommunicable diseases, leading to a considerable health, social and economic burden,³ and that while there have been notable improvements in some countries, the burden of poor oral health remains, especially among the most vulnerable in society;

Noting that untreated dental caries (tooth decay) in permanent teeth occurs in 2.3 billion people, more than 530 million children have untreated dental caries of primary teeth (milkteeth) and 796 million

¹ See Annex 4 for the financial and administrative implications for the Secretariat of this resolution.

² Document A74/10 Rev.1.

³ GBD 2017 Disease and Injury Incidence and Prevalence Collaborators. Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017. *Lancet*. 2018;392(10159):1789–1858. doi: 10.1016/S0140-6736(18)32279-7.

people are affected by periodontal diseases;¹ noting also that early rates of childhood caries are highest among those in vulnerable situations; and aware that these conditions are largely preventable;

Noting also that oral cancers are among the most prevalent cancers worldwide with 180 000 deaths each year,² and that in some countries they account for the most cancer-related deaths among men;

Noting further the economic burden due to poor oral health and that oral diseases worldwide account for US\$ 545 billion in direct and indirect costs,³ ranking poor oral health among the most costly health domains, such as diabetes and cardiovascular diseases;

Also taking into account that poor oral health – apart from pain, discomfort and lack of well-being and quality of life – leads to school and workplace absenteeism,⁴ leading to shortfalls in learning and productivity losses;

Concerned about the effect of poor oral health on quality of life and healthy ageing both physically and mentally; and noting that poor oral health is a regular cause of pneumonia for elderly people, particularly those living in care facilities, and for persons with disabilities;

Aware that poor oral health is a major contributor to general health conditions, and noting that it has particular associations with cardiovascular diseases, diabetes, cancers, pneumonia and premature birth;⁵

Noting that noma, a necrotizing disease starting in the mouth, is fatal for 90% of affected children in poor communities, mostly in some regions in Africa, and leads to lifelong disability and often social exclusion;

Concerned that the burden of poor oral health reflects significant inequalities, between and within countries, disproportionately affecting low- and middle-income countries, mostly affecting people from lower socioeconomic backgrounds and other risk groups, such as persons who cannot maintain their oral hygiene on their own due to their age or disability;

Acknowledging the many risk factors that oral diseases share with noncommunicable diseases, such as tobacco use, harmful use of alcohol, a high intake of free sugars and poor hygiene, and therefore the necessity to integrate strategies on oral health promotion, prevention and treatment into overall noncommunicable disease policies;

¹ GBD 2017 Oral Disorders Collaborators, Bernabe E, Marcenes W, Hernandez CR, Bailey J, Abreu LG, et al. Global, regional, and national levels and trends in burden of oral conditions from 1990 to 2017: A systematic analysis for the Global Burden of Disease 2017 study. *J Dent Res.* 2020;99(4):362-373. doi: 10.1177/0022034520908533.

² International Agency for Research on Cancer, Global Cancer Observatory. Lip, oral cavity. December 2020. Lyon: Global Cancer Observatory, International Agency for Research on Cancer; December 2020 (<https://gco.iarc.fr/today/data/factsheets/cancers/1-Lip-oral-cavity-fact-sheet.pdf>, accessed 5 May 2021).

³ Righolt AJ, Jevdjevic M, Marcenes W, Listl S. Global-, regional-, and country-level economic impacts of dental diseases in 2015. *J Dent Res.* 2018;97(5):501-507. doi: 10.1177/0022034517750572.

⁴ Peres MA, Macpherson LMD, Weyant RJ, Daly B, Venturelli R, Mathur MR et al. Oral diseases: a global public health challenge. *Lancet.* 2019;394(10194):249-260. doi: 10.1016/S0140-6736(19)31146-8.

⁵ Seitz MW, Listl S, Bartols A, Schubert I, Blaschke K, Haux C et al. Current knowledge on correlations between highly prevalent dental conditions and chronic diseases: an umbrella review. *Prev Chronic Dis.* 2019;16:E132180641. doi: 10.5888/pcd16.180641.

Recognizing that adequate intake of fluoride plays an important role in the development of healthy teeth and in the prevention of dental caries; and recognizing the need to mitigate the adverse effects of excessive fluoride in water sources on the development of teeth;¹

Concerned about the potential environmental impact caused by the use and disposal of mercury-containing dental amalgam, and the use of toxic chemicals for developing X-ray photographs;

Concerned also that oral health services are among the most affected essential health services because of the coronavirus disease (COVID-19) pandemic, with 77% of countries reporting partial or complete disruption;

Highlighting the importance of oral health and interventions with a life course approach;

Noting that a number of oral and dental conditions can act as indicators of neglect and abuse, especially among children, and that oral health professionals can contribute to the detection of child abuse and neglect,

1. URGES Member States, taking into account their national circumstances:

- (1) to understand and address the key risk factors for poor oral health and associated burden of disease;
- (2) to foster the integration of oral health within their national policies, including through the promotion of articulated interministerial and intersectoral work;
- (3) to reorient the traditional curative approach, which is basically pathogenic, and move towards a preventive promotional approach with risk identification for timely, comprehensive and inclusive care, taking into account all stakeholders in contributing to the improvement of the oral health of the population with a positive impact on overall health;
- (4) to promote the development and implementation of policies to promote efficient workforce models for oral health services;
- (5) to facilitate the development and implementation of effective surveillance and monitoring systems;
- (6) to map and track the concentration of fluoride in drinking water;
- (7) to strengthen the delivery of oral health services as part of the essential health services package that deliver universal health coverage;
- (8) to improve oral health worldwide by creating an oral health-friendly environment, reducing risk factors, strengthening a quality-assured oral health care system and raising public awareness of the needs and benefits of good dentition and a healthy mouth;

2. CALLS ON Member States:

- (1) to frame oral health policies, plans and projects for the management of oral health care according to the vision and political agendas in health projected for 2030, in which oral health is

¹ Petersen PE, Lennon MA. Effective use of fluorides for the prevention of dental caries in the 21st century: the WHO approach. *Community Dent Oral Epidemiol.* 2004;32(5):319-21. doi: 10.1111/j.1600-0528.2004.00175.x.

considered an integral part of general health, responding to the needs and demands of the public for good oral health;

(2) to strengthen cross-sectoral collaboration across key settings, such as schools, communities and workplaces, to promote good habits and healthy lifestyles, integrating teachers and families;

(3) to enhance oral health professionals' capacities to detect potential cases of neglect and abuse, and provide them with the appropriate and effective means to report such cases to the relevant authority according to the national context;

3. REQUESTS the Director-General:

(1) to develop, by 2022, a draft global strategy, in consultation with Member States, on tackling oral diseases, aligned with the global action plan for the prevention and control of noncommunicable diseases 2013–2030 and pillars 1 and 3 of WHO's Thirteenth General Programme of Work, 2019–2023 for consideration by the governing bodies in 2022;

(2) to translate this global strategy, by 2023, into an action plan for public oral health, including a framework for tracking progress with clear measurable targets to be achieved by 2030, encompassing control of tobacco use, betel quid and areca nut chewing, and alcohol use – and community dentistry, health promotion and education, prevention and basic curative care – providing a basis for a healthy mouth, where no one is left behind; this action plan should also contain the use of provisions that modern digital technology provides in the field of telemedicine and teledentistry;

(3) to develop technical guidance on environmentally friendly and less-invasive dentistry to support countries with their implementation of the Minamata Convention on Mercury, including supporting preventive programmes;

(4) to continue to update technical guidance to ensure safe and uninterrupted dental services, including during health emergencies;

(5) to develop best buy interventions on oral health, as part of an updated Appendix 3 to the global action plan on the prevention and control of noncommunicable diseases and integrated into the Universal Health Coverage Compendium;

(6) to include noma in the planned WHO 2023 review process to consider the classification of additional diseases within the road map for neglected tropical diseases 2021–2030;

(7) to report on progress and results until 2031 as part of the consolidated report on noncommunicable diseases, in accordance with paragraph 3(e) of decision WHA72(11) (2019).

(Seventh plenary meeting, 31 May 2021 –
Committee A, first report)

WHA74.6 Strengthening local production of medicines and other health technologies to improve access¹

The Seventy-fourth World Health Assembly,

Having considered the consolidated report by the Director-General;²

Recalling 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 technologies;³

Recalling resolution WHA61.21 (2008), decision WHA71(9) (2018) and document A71/12 (2018), insofar as they address the role of technology transfer and local production of medicines and other health technologies in improving access;

Recalling also United Nations General Assembly resolution 74/306 (2020) and resolution WHA73.1 (2020) on comprehensive and coordinated response to the coronavirus disease (COVID-19) pandemic, which call for intensified international cooperation and solidarity to contain, mitigate and overcome the pandemic and its consequences through responses that are people-centred and gender-sensitive, with full respect for human rights;

Recalling also the Human Rights Council resolution 12/24 (2009) on access to medicine in the context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health;

Recalling further the 2030 Agenda for Sustainable Development and its aim of ensuring that no one is left behind;

Recalling also the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) as amended, and recalling the 2001 Doha Declaration on the TRIPS Agreement and Public Health, which affirms that the TRIPS Agreement can and should be interpreted and implemented in a manner supportive of the right of Member States to protect public health and, in particular, to promote access to medicines for all, and recognizes that intellectual property protection is important for the development of new medicines and also recognizes the concerns about its effects on prices;

Noting the discussions in WTO and other relevant international organizations including on innovative options to enhance the global effort towards the production and equitable distribution of COVID-19 medicines and other health technologies through local production;

Acknowledging Member States' commitment to achieve the Sustainable Development Goals including those that relate to local production of medicines and other health technologies in various ways (for example, Goals 3, 8 and 9);

¹ See Annex 4 for the financial and administrative implications for the Secretariat of this resolution.

² Document A74/9.

³ Medicines and other health technologies includes pharmaceuticals, vaccines, biopharmaceuticals and medical devices.

Recognizing that some countries face problems in accessing medicines, vaccines and other essential health technologies due to factors such as low manufacturing capacity and high prices, among others, and that such problems can be exacerbated in times of public health emergencies and/or overwhelming demand, such as during the COVID-19 pandemic;

Recalling WHO's road map for access to medicines, vaccines and other health products 2019–2023 as part of comprehensive support for access and strategic local production, while considering regional plans and initiatives;

Emphasizing the need to improve access to quality, safe, effective and affordable medicines and other health technologies, inter alia, through building capacity for local production, especially in low- and middle-income countries, technology transfer on voluntary and mutually agreed terms, cooperation with, support to and development of voluntary patent pools and other voluntary initiatives, such as the WHO COVID-19 Technology Access Pool and the Medicines Patent Pool, and promoting generic competition in line with WHO's road map for access to medicines, vaccines and other health products 2019–2023;

Recognizing that integration of local production into overall health systems strengthening can contribute to sustainable access to quality-assured, safe, effective and affordable medicines and other health technologies, and can help to prevent or address medical product shortages, achieving universal health coverage and strengthening of national health emergency preparedness and response and minimizing public health hazards;

Recognizing also that local production can contribute to other national development goals, such as catalysing local capacity in innovation, strengthening human capital and expertise and building a knowledge-based economy;

Recognizing further that the COVID-19 pandemic has highlighted the critical need to prepare for potential disruptions of the supply chain for essential medicines and other health technologies, including through the strengthening of local production;

Also recognizing the importance of promoting competition to improve availability and affordability of health technologies consistent with public health policies and needs, inter alia through the production and introduction of generic versions, in particular of essential medicines, in developing countries;

Noting that the local production of medicines and other health technologies can provide for greater sustainability of supply chains, especially in public health emergencies;

Noting that the inter-agency statement on promoting local production¹ signed by six organizations (the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNAIDS, UNCTAD, UNICEF, UNIDO and WHO) calls for a holistic approach, close partnership, interministerial and relevant stakeholder cooperation, and global synergy in promoting quality and sustainable local production of safe, effective, quality and affordable medicines and other health technologies;

¹ Interagency statement on promoting local production of medicines and other health technologies. 2019. (https://www.who.int/phi/implementation/tech_transfer/Interagency-statement-on-promoting-local-production.pdf?ua=1, accessed 7 January 2021).

Recognizing the work of the Interagency Pharmaceutical Coordination Group hosted by WHO and the role of Unitaid and the Medicines Patent Pool to help countries to enhance their access to medicines particularly for HIV/AIDS, tuberculosis and malaria;

Recalling the launch of the Access to COVID-19 Tools (ACT) Accelerator, which is a global collaboration that seeks to accelerate development, production, and equitable access to COVID-19 diagnostics, therapeutics, and vaccines, and which is supported by the health systems connector;

Noting that, with globalization and the variety of country contexts, there is no “one size fits all” approach in promoting local production;

Recognizing that the small size of some Member States’ economies poses a challenge for local production, which could be addressed by regional market integration;

Emphasizing the need to ensure the quality, safety, efficacy, effectiveness and affordability of locally-produced medicines and other health technologies including through effective manufacturing and regulatory systems;

Noting that the benefits and sustainability of local production are dependent on, among others, a functioning pharmaceutical value chain: from research and development, manufacturing and regulation through to pricing and reimbursement, supply chains, and prescribing and dispensing by health workers as well as stewardship to ensure judicious and appropriate use;

Acknowledging with appreciation the many existing national, regional and global efforts, as well as the achievements made by the Member States, to promote quality and sustainable local production of safe, effective and affordable medicines and other health technologies to benefit public health needs;

Noting that local production can contribute towards achieving the triple billion targets of WHO’s Thirteenth General Programme of Work, 2019–2023;

Noting with concern that Member States still face many challenges in establishing and strengthening sustainable local production of quality-assured, safe, effective and affordable medicines and other health technologies to benefit public health systems and public health needs,

1. URGES Member States,¹ where appropriate, based on the national context:
 - (1) to strengthen their leadership, commitment and support in promoting the establishment and strengthening of quality and sustainable local production of medicines and other health technologies that follows good manufacturing practices;
 - (2) to align their national and regional policies and strategies related to local production, and to leverage regional economic integration and coordination platforms to support products with sizeable regional demand to expand access to markets and enhance sustainability of local production;
 - (3) to develop evidence-based holistic national and regional policies, financing mechanisms, strategies and plans of action, and to explore appropriate mechanisms to support the sustainable implementation of national/regional strategies for local production in collaboration with

¹ And, where applicable, regional economic integration organizations.

stakeholders for strengthening the local production of quality, safe, effective and affordable medicines and other health technologies;

(4) to enhance interministerial policy coherence and to create incentives and an enabling business environment for local production to be quality-assured and sustainable;

(5) to apply a holistic approach in strengthening local production by considering, for example, promoting research and development, transparency of markets for medicines and other health technologies, regulatory systems strengthening, access to sustainable and affordable financing, development of skilled human resources, access to technology transfer on voluntary and mutually agreed terms for production and needs-based innovation, the aggregation of national and regional demand, and appropriate incentives for private-sector investment, particularly in the context of achieving universal health coverage;

(6) to engage in global, regional and subregional networks related to promoting sustainable local production of quality, safe, effective and affordable medicines, and to further enhance multistakeholder collaboration;

(7) to further engage in North–South and South–South development cooperation, partnerships and networks to build and improve the transfer of technology related to health innovation on voluntary and mutually agreed terms and in line with their international obligations;

(8) to take into account the rights and obligations in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement), including those affirmed by the Doha Declaration on the TRIPS Agreement and Public Health, in order to promote access to medicines and other health technologies for all;

2. REQUESTS the Director-General:

(1) to continue to support Member States by strengthening actions related to resolutions WHA61.21 (2008), WHA66.22 (2013) and WHA67.20 (2014);

(2) to strengthen WHO's role in providing leadership and direction in promoting the strategic use of quality and sustainable local production of medicines and other health technologies by using a holistic approach and following good manufacturing practices;

(3) to raise awareness of the importance of sustainable local production of safe, effective, quality, and affordable medicines and other health technologies in improving access;

(4) to continue to support Member States upon their request in promoting quality and sustainable local production of medicines and other health technologies, including, as appropriate, by:

(a) providing technical support to Member States in developing and/or implementing national policies and evidence-based comprehensive strategies and plans of action for sustainable local production;

(b) supporting Member States to foster strategic and collaborative partnerships, including research and manufacturing;

(c) building capacity of Member States towards policy coherence and creating an enabling environment;

- (d) building capacity of governments and other stakeholders to strengthen local production towards quality assurance, regulatory approval and WHO prequalification, as appropriate;
 - (e) strengthening regulatory systems and regional regulatory collaboration;
 - (f) supporting Member States in facilitating research and development and technology transfer on voluntary and mutually agreed terms and in line with their international obligations for local production of quality-assured, prioritized medicines and other health technologies to prevent and address shortages and/or specific public health needs;
 - (g) exploring a mechanism for collecting and disseminating local production-related market intelligence including on the impact of local production measures on availability, accessibility, affordability and prices of local health technologies in collaboration with other relevant international organizations and agencies;
- (5) to encourage greater participation of Member States in existing regional and global initiatives for collaboration and cooperation;
 - (6) to foster, and coordinate with relevant international intergovernmental organizations in promoting, local production in a strategic and collaborative approach;
 - (7) to leverage existing and, if needed, establish new global platforms to promote transfer of technology on voluntary and mutually agreed terms and in line with international obligations and local production under North–South and South–South cooperation;
 - (8) to continue to support local production by dedicating staff and sufficient resources to carry out activities under this resolution at all three levels of the Organization;
 - (9) to continue to provide technical support, as appropriate, upon request, in collaboration with other competent international organizations, in particular WIPO and WTO, including to policy processes and to countries that intend to make use of the provisions contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement), including the flexibilities affirmed by the Doha Declaration on the TRIPS Agreement and Public Health in order to promote access to pharmaceutical products;
 - (10) to continue to support transparency of prices and economic data along the value chain of medicines, including locally produced medicines, and other health technologies (including the supply chain) in order to promote access and affordability;
 - (11) to report on progress in the implementation of this resolution to the Health Assembly biennially from 2023 to 2027.

(Seventh plenary meeting, 31 May 2021 –
Committee A, third report)

WHA74.7 Strengthening WHO preparedness for and response to health emergencies¹

The Seventy-fourth World Health Assembly,

Having considered the consolidated report by the Director-General;²

Recalling decision EB148(2) (2021) on strengthening WHO's global health emergency preparedness and response, which called for the development of a resolution in this regard;

Reaffirming that the objective of WHO is the attainment by all peoples of the highest possible level of health;

Reaffirming also that the Constitution of WHO defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, and declares that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Further reaffirming the functions set out in Article 2 of the WHO Constitution in order for the Organization to achieve its objective, inter alia: to act as the directing and coordinating authority on international health work; to stimulate and advance work to eradicate epidemic, endemic and other diseases; to furnish appropriate technical assistance, and, in emergencies, necessary aid upon the request or acceptance of governments; and to propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform such duties as may be assigned thereby to the Organization and are consistent with its objective; and acknowledging the Organization's work to achieve this and to perform the tasks assigned by Member States, including normative work;

Reaffirming also resolution WHA58.3 (2005) on the revision of the International Health Regulations and further reaffirming the principles of the International Health Regulations (2005) set out in its Article 3, including that the implementation of the Regulations shall be with full respect for the dignity, human rights and fundamental freedoms of persons, and guided by the goal of their universal application for the protection of all people of the world from the international spread of disease as well as by the Charter of the United Nations and WHO's Constitution and the sovereign right of Member States to legislate and implement legislation in pursuance of their health policies in this regard;

Recalling resolution WHA73.8 (2020) on strengthening preparedness for health emergencies: implementation of the International Health Regulations (2005) in which, inter alia, the Health Assembly urged Member States to fully comply with the Regulations and to take actions to implement the unmet obligations thereof;

Recalling also resolution WHA73.1 (2020) on COVID-19 response, in which the Health Assembly requested the Director-General to, inter alia, continue to build and strengthen the capacities of WHO at all levels to fully and effectively perform the functions entrusted to it under the International Health Regulations (2005);

Underlining that preparing for and responding to health emergencies is primarily the responsibility and crucial role of governments;

¹ See Annex 4 for the financial and administrative implications for the Secretariat of this resolution.

² Document A74/9.

Recalling decision WHA69(9) (2016), which recognized the establishment of the WHO Health Emergencies Programme, allocated a budget to it and set up the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme;

Acknowledging the importance of strengthened multilateral cooperation within the United Nations system taking into account, as appropriate, relevant United Nations General Assembly resolutions, including resolutions on the quadrennial comprehensive policy review of operational activities for development of the United Nations system in preparing for and responding to health emergencies and limiting their direct and indirect negative impacts;

Acknowledging also the key leadership role of WHO within the United Nations system in preparing for and in catalysing and coordinating a comprehensive, early, effective, transparent, sustainable response to health emergencies that is age- and disability-sensitive and gender-responsive, that ensures respect for human rights and fundamental freedoms, and that recognizes the centrality of Member States' efforts therein;

Recognizing WHO's role in the international humanitarian system, including through leadership and coordination of the Inter-Agency Standing Committee Global Health Cluster and as provider of last resort in health emergencies, acknowledging the role of other humanitarian actors, including nongovernmental organizations and the International Red Cross and Red Crescent Movement therein, and reaffirming the principles of neutrality, humanity, impartiality and independence in the provision of humanitarian assistance, and in this regard recalling United Nations General Assembly resolution 46/182 of 19 December 1991 on the strengthening of the coordination of humanitarian emergency assistance of the United Nations and all subsequent General Assembly resolutions on the subject, including resolution 75/127 of 11 December 2020, and underscoring that respect for international law, including international humanitarian law, is essential to respond to health emergencies in armed conflicts and mitigate their impact;

Recognizing also that attacks on medical and health personnel result in long-lasting impacts, including the loss of life and human suffering, weaken the ability of health systems to deliver essential life-saving services and produce setbacks for health development; and recalling in that regard United Nations General Assembly resolution 75/125 of 11 December 2020 on the safety and security of humanitarian personnel and protection of United Nations personnel, as well as resolution WHA65.20 (2012);

Noting with concern that the COVID-19 pandemic has revealed serious shortcomings in preparedness for, timely and effective prevention and detection of, as well as response to potential health emergencies, including in the capacity and resilience of health systems, indicating the need to better prepare for future health emergencies;

Acknowledging the importance of timely identification and notification of events that may constitute a public health emergency of international concern, in accordance with relevant provisions of the International Health Regulations (2005), and acknowledging the critical role played by international cooperation and timely and transparent sharing of epidemiological and clinical data, biological samples, knowledge and information, including timely sharing of pathogen genetic sequence data, and in this context recalling the Convention on Biological Diversity and its objectives and principle and the Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization to the Convention on Biological Diversity and its objective, taking into account relevant national and international laws, regulations, obligations and frameworks, in order to facilitate rapid responses to public health emergencies that equitably benefit all the countries, while taking note of the role that voluntary transfer of technology and know-how on mutually agreed terms plays for scaling up research and development and local manufacturing of health products;

Recognizing the critical importance in preparing for future health emergencies of agile, well-coordinated and tested capacities in Member States, including core capacities required under the International Health Regulations (2005), necessary for an effective health emergency response, including strong public health expertise and effective science-based coordination to ensure evidence-based decision-making processes across government agencies;

Recognizing also that the COVID-19 pandemic and its health, economic and social consequences, including increasing gender and other inequalities, have further underlined the need for multilateral cooperation, unity and solidarity to protect public health and to prepare for and respond to health emergencies, across all sectors, using holistic, all-hazards and One Health approaches, recognizing the interconnectedness between the health of humans, animals, plants and their shared environment, including through collaboration between WHO, FAO, OIE and UNEP;

Recalling United Nations General Assembly resolutions 74/270 (2020) on global solidarity to fight the coronavirus disease 2019 (COVID-19), 74/274 (2020) on international cooperation to ensure global access to medicines, vaccines and medical equipment to face COVID-19, 74/306 (2020) on comprehensive and coordinated response to the coronavirus disease (COVID-19) pandemic, 74/307 (2020) on united response against global health threats: combating COVID-19, 75/17 (2020) on international cooperation to address challenges faced by seafarers as a result of the COVID-19 pandemic to support global supply chains, 75/27 (2020) on International Day of Epidemic Preparedness, 75/156 (2020) on strengthening national and international rapid response to the impact of the coronavirus disease (COVID-19) on women and girls and 75/157 (2020) on women and girls and the response to the coronavirus disease (COVID-19);

Recalling also United Nations General Assembly resolution 74/2 (2019), which recognizes that universal health coverage is fundamental for achieving the Sustainable Development Goals, while reaching the goals and targets included throughout the 2030 Agenda for Sustainable Development is critical for the attainment of healthy lives and well-being for all, and recognizing that the COVID-19 pandemic is hampering the achievement of the Sustainable Development Goals, including universal health coverage;

Recognizing the acute direct and indirect impacts of the COVID-19 pandemic, including increased violence against women and girls, particularly in fragile situations already affected by conflict, crime, violence, disasters, climate change and displacement, and in this regard acknowledging the importance of the WHO Health Emergencies Programme's work in both acute and protracted crises;

Acknowledging the importance of strong, resilient and agile health systems with integrated public health functions, a competent and well-trained health workforce, timely and equitable access to quality health services, including those for strong routine immunization, mental health and psychosocial support, trauma recovery, sexual and reproductive health, and maternal, newborn and child health, as well as equitable access to quality, safe, effective and affordable technologies and products to strengthen multisectoral collaboration among all stakeholders for achieving universal health coverage;

Highlighting the role of WHO in facilitating universal and equitable access to quality health services without financial hardship, in all countries, particularly those with weaker health systems and those affected by conflict, which is critical for preparedness and resilience during health emergencies;

Recognizing that country responses to health emergencies will necessarily be tailored to national circumstances, and that WHO has a role in providing advice and support to countries to achieve universal health coverage, thus facilitating universal access to health services;

Acknowledging the many negative consequences of the COVID-19 pandemic on society, public health, human rights and the economy, which have disproportionately affected certain groups, such as persons with disabilities, disrupted the provision of essential health services, and have caused challenges

such as interruptions to routine care, delayed immunizations, postponed diagnoses, treatments and mental health care and limited resources for the health and care workforce to address these needs, as well as the multitude and complexity of necessary immediate and long-term actions with the ambition to achieve the Sustainable Development Goals;

Acknowledging also the impact of disruptions to global travel and trade on efforts to mobilize a robust, international response to COVID-19, as well as on efforts to sustain humanitarian assistance and vital longer-term development programmes;

Recognizing the critical role of international collaboration in research and development, including in multicountry clinical and vaccine trials, as well as rapid diagnostics test and assay development, but acknowledging the need for further rigorous scientific evidence, protocols, standards and international collaboration to assess the role and impact of public health and societal interventions and for evidence-informed decision-making in public health emergencies;

Underscoring that fair and equitable access to health products is a global priority and that the availability, accessibility, acceptability and affordability of health products and health services of assured quality are fundamental to tackling global public health emergencies, and in this regard noting the role played by WHO in initiatives such as the Access to COVID-19 Tools (ACT) Accelerator, and recognizing the collaborative and inclusive approach adopted by all of its participating international health partners and the development of voluntary patent pools and other voluntary initiatives, such as the COVID-19 Technology Access Pool;

Recognizing that due to the geographical location of landlocked developing countries and small island developing States, and their dependence on transit countries for exports and imports of goods, access to health products has been particularly affected;

Recognizing also the need for sharing of health-related technologies on voluntary and mutually agreed terms, and in line with relevant international obligations, in implementing and supporting public health measures and bolstering national response efforts to COVID-19 and other future public health emergencies of international concern;

Further recognizing the value of greater collaboration between the public and private sectors in facilitating transparency in investments and costs along the research, development and production chain, and in facilitating affordability;

Recognizing also the potential of digital health technologies to strengthen secure communication in health emergencies, to implement and support public health measures, and bolster national response efforts to pandemics, epidemics and other health emergencies, to protect and empower individuals and communities, while ensuring personal data protection, including by building on the global strategy on digital health 2020–2025;

Noting the negative impact of misinformation, disinformation and stigmatization on preparedness and response to health emergencies, and on people's physical and mental health, and the need to counter mis- and disinformation and stigmatization in the context of health emergencies, and recognizing that for all stakeholders to be part of the response, they need to have access to timely and accurate information and to be involved in decisions that affect them;

Noting also the need for whole-of-government and whole-of-society Member State coordination and inclusive collaboration among all stakeholders during public health emergencies;

Further noting the independent reviews and evaluations of preparedness and response following the severe acute respiratory syndrome (SARS) epidemic, the A(H1N1) influenza pandemics and the

2014–2016 Ebola virus disease epidemic, which have highlighted shortcomings in the global capacity to prepare for, detect, report and respond to outbreaks in a transparent and timely manner and have made numerous and specific recommendations to address these shortcomings;

Recalling resolution WHA73.1 (2020), which requested the Director-General to initiate, at the earliest appropriate moment, and in consultation with Member States, a stepwise process of impartial, independent and comprehensive evaluation, and noting that this included using existing mechanisms, as appropriate, to review experience gained and lessons learned from the WHO-coordinated international health response to COVID-19;

Taking note of the report of the Director-General,¹ the report of the Independent Panel for Pandemic Preparedness and Response,² the report of the Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 response,³ the report of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme;⁴

Taking note also of the report of the Global Preparedness Monitoring Board;⁵

Recalling the ongoing efforts to strengthen WHO, including through the WHO transformation agenda and the triple billion targets in WHO's Thirteenth General Programme of Work, 2019–2023;

Stressing the need for effective and accountable management, enhanced inclusive and meaningful participation of and engagement with Member States at all levels of governance across WHO, including making full use of the governing bodies, to enable Member States to provide informed advice and direction on WHO's work, especially during health emergencies;

Stressing the need to strengthen the technical and normative role of WHO as the directing and coordinating authority for international health work, and its capacity to provide technical advice and support in a timely manner to Member States, upon their request, including at the country level;

Acknowledging that the international community's expectations, while varying according to national contexts, generally outweigh WHO's current capacities and its ability to provide support to Member States in developing strong, resilient, quality, inclusive and efficient health systems for emergency outbreak prevention and response and that deliver high-quality, affordable services to all those in need, leaving no one behind;

Acknowledging that WHO should be adequately and sustainably resourced to fulfil its functions in an effective, efficient and strategic way and that future reforms to facilitate this should take into account the outcome of the discussions of the Working Group on Sustainable Financing;

Recalling decision EB148(12) (2021), in which the Executive Board decided to establish the Working Group on Sustainable Financing to enable WHO to have the robust structures and capacities needed to fulfil its core functions as defined in the Constitution and decided that the Working Group

¹ Document A74/9.

² See document A74/INF./2.

³ Document A74/9 Add.1.

⁴ Document A74/16.

⁵ A world in disorder. Global Preparedness Monitoring Board annual report 2020. Geneva: World Health Organization; 2020 (https://apps.who.int/gpmb/annual_report.html#:~:text=Annual%20Reports,-A%20World%20in&text=The%20Board%20called%20for%20five,robust%20global%20governance%20of%20preparedness,accessed%2024%20May%202021), accessed 24 May 2021).

shall submit its final report with its recommendations and other findings to the Executive Board at its 150th session;

Expressing its highest appreciation of and support for the dedication, efforts and sacrifices of health professionals, health workers and other relevant front-line workers, as well as all those in the three levels of the Organization, who have gone above and beyond the call of duty in responding to the COVID-19 pandemic,

1. DECIDES to establish a Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies, which is open to all Member States;¹
2. REQUESTS the Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies to consider the findings and recommendations of the Independent Panel for Pandemic Preparedness and Response, the IHR Review Committee and the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme, taking into account relevant work of WHO, including that stemming from resolution WHA73.1 (2020) and decision EB148(12) (2021), as well as the work of other relevant bodies, organizations, non-State actors and any other relevant information;
3. RECOMMENDS that, following regional consultations to be finalized by end of June 2021, the Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies shall have a Bureau comprising six officers (two Co-Chairs and four Vice-Chairs, to be appointed at the first meeting), one from each WHO region;
4. REQUESTS that the Co-Chairs and Vice-Chairs shall facilitate the work of the Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies in close dialogue with its membership;
5. REQUESTS ALSO the Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies to work in an inclusive manner and to define and agree on its working methods;
6. FURTHER REQUESTS the Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies to submit a report with proposed actions for the WHO Secretariat, Member States, and non-State actors, as appropriate, for consideration by the Seventy-fifth World Health Assembly in 2022 through the Executive Board at its 150th session;
7. URGES Member States:¹
 - (1) to increase and improve efforts to build, strengthen and maintain the capacities required under the International Health Regulations (2005) and to continue to report annually to the Health Assembly on the implementation of the International Health Regulations (2005), using as appropriate, available tools included in the International Health Regulations (2005) monitoring and evaluation framework;
 - (2) to strengthen their core public health capacities and workforce for indicator-based and early-warning surveillance, based, inter alia, on disease-specific surveillance, syndromic surveillance, event-based surveillance of health-related behaviour, surveillance data relating to animal and environmental health, enabling detection of public health events requiring rapid

¹ And regional economic integration organizations as appropriate.

assessment, notification and public health response, in order to ensure that all relevant events are rapidly detected and controlled;

(3) to adopt an all-hazard, multisectoral, coordinated approach in preparedness for health emergencies, recognizing the links between human, animal and environmental health and the need for a One Health approach;

(4) to increase their capacity to detect new threats, including through laboratory techniques, such as genomic sequencing;

(5) to notify WHO of public health events within their respective territories according to relevant provisions of the International Health Regulations (2005), including any events that may cause a public health emergency of international concern, as well as any health measures implemented in response to those events; and to continue to communicate to WHO timely, accurate and sufficiently detailed public health information and laboratory results available to them on these events, as well as on the difficulties faced and support needed in responding to these events;

(6) to share with their population and the global community reliable and comprehensive information on health emergencies and the public health responses to be taken by local, national, regional and international public health authorities, and to take measures to strengthen health literacy and to counter misinformation, disinformation and stigmatization, including by providing access to other sources of fact- and science-based information;

(7) to strengthen cooperation to create mechanisms for communication, coordination and articulation of programmes and policies on health issues, considered of shared interest, between linked border localities, to adequately respond to risks and public health emergencies of international concern;

(8) to work towards achieving strong and resilient health systems and universal health coverage, as an essential foundation for effective preparedness and response to public health emergencies, and adopt an equitable approach to preparedness and response activities, including to mitigate the risk that health emergencies exacerbate existing inequalities in access to services, including those for immunization and nutrition, chronic infectious diseases and noncommunicable diseases, mental health, maternal and child health, sexual and reproductive health care services, rehabilitation and long-term care;

(9) to take steps to ensure that the response to health emergencies and pandemics does not exacerbate other global health challenges, including the ongoing necessity to tackle issues such as lack of access to health services and medicines, the burden of neglected diseases, and the necessity to preserve the efficacy of antimicrobials, particularly antibacterials, including through appropriate stewardship, prudent use and sustainable access;

(10) to cooperate in order to facilitate cross-border travel of persons for essential purposes during a health emergency and avoid unnecessary interference with trade without undermining efforts to prevent the spread of the causative pathogen, in accordance with the International Health Regulations (2005);

(11) to support stronger coordination with relevant multilateral organizations to improve understanding and mechanisms to deal with travel and trade considerations, including on how best to delink travel from trade restrictions during public health emergencies of international concern, pursuant to the International Health Regulations (2005), with the goal of maximizing the effectiveness of public health measures while minimizing negative economic impacts, including

by facilitating the manufacturing and movement of critical medical supplies essential to the public health response;

(12) to take steps to prevent, within their respective legal frameworks and contexts, speculation and undue stockpiling that may hinder access to safe, effective and affordable essential medicines, vaccines, medical equipment and other health products, as may be required to effectively tackle health emergencies;

(13) to keep transport networks and supply chains open in order to facilitate timely, equitable and affordable access to essential, safe, affordable, quality and effective medical products, especially for landlocked developing countries and small island developing States;

(14) to support and work on enhancing regional and international cooperation mechanisms to ensure universal, timely and equitable access to and fair distribution of quality, safe, effective and affordable essential health technologies and products, including their components and precursors during global health emergencies;

(15) to promote an enhanced response to future pandemics based on the lessons learned from the COVID-19 pandemic and other public health emergencies of international concern, taking into account all the obstacles that impeded the effective response to and treatment of the disease as well as the need for all countries to have unhindered access to vaccines and essential health products;

(16) to strengthen WHO's capacity to rapidly and appropriately assess disease outbreaks that may potentially constitute a public health emergency of international concern as early as possible, in close coordination and consultation with Member States, and to systematically communicate the results of such assessments to Member States;

(17) to seek to ensure the adequate, flexible, sustainable and predictable financing of WHO's Programme budget including the WHO Health Emergencies Programme as well as the Contingency Fund for Emergencies, and to follow up on the recommendations of the Working Group on Sustainable Financing;

8. CALLS ON international actors, partners, civil society and the private sector:

(1) to support all countries, upon their request, in implementing their multisectoral national action plans, in strengthening their health systems to respond to health emergencies, and in maintaining the safe provision of all other essential public health functions and services during them;

(2) to strengthen partnerships, global coordination and cooperation in response to infectious diseases based on lessons learned from the COVID-19 pandemic and previous public health emergencies of international concern and fostering a One Health, whole-of-society and health systems strengthening approach, including between WHO and relevant multilateral organizations, including the signatory agencies of the global action plan for healthy lives and well-being for all;

(3) to address – where relevant, in coordination with Member States – the proliferation of disinformation and misinformation, particularly in the digital sphere, as well as the proliferation of malicious cyber-activities that undermine the public health response; and to support the timely provision of clear, objective and science-based data and information to the public;

9. REQUESTS the Director-General, as soon as practicably possible and in consultation with Member States:¹

(1) to strengthen the global, regional, national and subnational pandemic preparedness system, support implementation by States Parties of the International Health Regulations (2005) and of core capacities required under the International Health Regulations (2005), provide clear guidance regarding requirements for States Parties under the International Health Regulations (2005), build and strengthen tailor-made support and tools for States Parties through regional and country offices and continue working collectively and collaboratively with partners and States Parties to bridge identified gaps in core capacities required under the International Health Regulations (2005), including through international cooperation, when requested;

(2) to make recommendations to Member States to build a more robust, transparent, consistent, scientific, evidence-based and cohesive International Health Regulations (2005) monitoring and evaluation framework that enables accurate assessment and reporting on national capacities in consultation with States Parties as well as actions to improve implementation of the International Health Regulations (2005);

(3) to develop a detailed concept note to be included in the report by the Director-General to the Seventy-fifth World Health Assembly in 2022 for the consideration of Member States as they determine the next steps on the voluntary pilot phase of the Universal Health and Preparedness Review mechanism, based on the principles of transparency and inclusiveness, and on how it builds on existing International Health Regulations (2005) monitoring and evaluation framework components, with the aim to assess, improve and strengthen accountability, cooperation, trust and solidarity around overall preparedness;

(4) to lead an evidence-based process, in consultation with Member States,¹ relevant United Nations and other international organizations and other stakeholders, as appropriate, and taking into account the recommendations of the IHR Review Committee:

(i) to develop practical guidance for the implementation of the International Health Regulations (2005) to prevent, protect against, detect, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which do not unduly impede cross-border movement of people and supplies for essential purposes;

(ii) to prepare a report on the options, implications, benefits, possible consequences and potential risks of delinking travel from trade restrictions during public health emergencies of international concern determined pursuant to the International Health Regulations (2005), with the goal of maximizing the effectiveness of public health measures while minimizing their economic impacts;

(iii) to develop recommendations, taking into consideration national circumstances, on the appropriate implementation of travel restrictions, including guidance to support countries to facilitate the return of citizens and permanent residents to their territories and, vice versa, and to facilitate the departure from and transit through their territory of nationals and permanent residents of third countries;

(iv) to develop guidance on situations that may occur in the context of international conveyances, seafaring and aviation during public health emergencies, such as outbreaks

¹ And regional economic integration organizations as appropriate.

on international cruise ships, including the division of roles and responsibilities of the various actors concerned when responding to such situations;

(v) to review and report on States Parties' experience with dispute settlement under Article 56 of the International Health Regulations (2005);

(5) to develop strategies and tools for managing the impact of health emergencies on gender equality, health systems and health service delivery, including by comprehensively increasing the resilience and capacity of health systems, in particular the health workforce, in the provision of essential public health functions and quality essential health services including those for strong routine immunization, mental health and psychosocial support, trauma recovery, sexual and reproductive health and maternal, newborn and child health during health emergencies with a view to achieving universal health coverage;

(6) to consider establishing risk communication strategies, adaptable to states and regions, including those to facilitate specific local capacity-building, mobilize financial and technical resources and, eventually, provide support to countries in elaborating goal-directed development plans, including performance indicators, as a key feature of public health systems' responsiveness;

(7) to develop a global framework to generate, monitor, compare and evaluate research and policies on public health and social interventions and assess their broader impact in order to harness global knowledge and expertise and to translate evidence into effective health emergency and preparedness policies;

(8) to review and strengthen or reform, as applicable, existing tripartite reporting mechanisms, such as the Global Early Warning System for Major Animal Diseases (GLEWS), improving communication and information exchange across existing surveillance networks across the One Health sectors;

(9) to build on and strengthen the existing cooperation between WHO, FAO, OIE and UNEP to develop options, for consideration by their respective governing bodies, including establishing a common strategy on One Health, including a joint workplan on One Health to improve prevention, monitoring, detection, control and containment of zoonotic disease outbreaks;

(10) to report on efforts to accumulate expertise on and raise visibility of One Health issues with a specific focus on zoonoses, including from wildlife, through the work of the One Health High-Level Expert Panel;

(11) to propose options to increase the transparency on the appointment, membership and deliberations of the IHR Emergency Committee including a more robust, transparent and inclusive risk assessment process, as well as detailed reporting of its proceedings, in particular in relation to its recommendations on declarations of, and suggested response measures to, public health emergencies of international concern, including options for the engagement of Member States with it;

(12) to make suggestions for potential intermediate and regional levels of alert, complementary to a public health emergency of international concern, with clear criteria and practical implications for countries;

(13) to provide support to countries, upon their request, in strengthening capacities to report on the information required under the International Health Regulations (2005), in particular under Articles 6–10, including the simplification and unification of reporting processes by States

Parties, and to strongly encourage compliance with the International Health Regulations (2005), including reporting and sharing of information at the earliest possible stage of an outbreak of epidemic of pandemic potential in line with Article 44, requiring States Parties to collaborate with each other, to the extent possible, in the detection and assessment of, and response to, events as provided under the Regulations;

(14) to make proposals on the use of digital technologies, by WHO and International Health Regulations (2005) States Parties and, as appropriate, other stakeholders, to upgrade and modernize communication on health emergency preparedness and response, including for the improved implementation of International Health Regulations (2005) obligations, through the development of an interoperability framework for secure global digital health information exchange, and support measures to counter the spread of stigmatization, misinformation and disinformation;

(15) to work together with Member States, the medical and scientific community, and laboratory and surveillance networks, to promote early, safe, transparent and rapid sharing of samples and genetic sequence data of pathogens of pandemic and epidemic, or other high-risk, potential, taking into account relevant national and international laws, regulations, obligations and frameworks, including, as appropriate, the International Health Regulations (2005), the Convention on Biological Diversity and the Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization and the Pandemic Influenza Preparedness Framework and the importance of ensuring rapid access to human pathogens for public health preparedness and response purposes;

(16) to provide support to countries, upon request, in developing and implementing national response plans to health emergencies, by developing, disseminating and updating normative products and technical guidance, learning tools, data and scientific evidence for public health responses, to provide accurate, timely and evidence-based information;

(17) in collaboration with Member States, to strengthen the capacities and capabilities of WHO to perform fully and effectively the functions entrusted to it under the International Health Regulations (2005), in particular through strategic health operations that provide swift support to countries in detection and assessment of and response to public health emergencies;

(18) to ensure that the advice and support provided by the WHO Secretariat to Member States to improve pandemic preparedness and response to public health emergencies takes into consideration different national circumstances and focuses, inter alia, on strengthening health systems;

(19) in collaboration with Member States,¹ other international organizations, civil society and the private sector, and based on lessons learned from the COVID-19 response and prior health emergencies, including experience in operationalizing the Access to COVID-19 Tools (ACT) Accelerator and the COVID-19 supply chain system, to propose strategies to enable rapid research, development, production and global equitable distribution of quality, safe, effective and affordable medical and other countermeasures and commodities at national, regional and global levels to respond to future health emergencies;

(20) to strengthen WHO's normative role, including by strengthening the technical capacity of the WHO Health Emergencies Programme, the Chief Scientist's Office, as appropriate, and the data and analytics and delivery team, and further leveraging WHO collaborating centres and

¹ And regional economic integration organizations as appropriate.

expert networks in order to enable the WHO Secretariat to rapidly disseminate high-quality, scientific, evidence-based timely, technical guidance that is practically applicable and tailored for country-level settings, and to make global expertise available to Member States, through all levels of WHO, including the WHO Academy;

(21) to strengthen global, regional and country preparedness and response capabilities and capacities for health emergencies by enhancing engagement of relevant stakeholders at all levels;

(22) to support efforts led by Member States to improve the transparency and effectiveness of United Nations system's efforts on pandemic preparedness and response, and work with the United Nations Secretary-General and all multilateral partners to enhance system-wide coherence;

(23) to strengthen the WHO Health Emergencies Programme's capacity to prepare for and respond to both acute and protracted humanitarian crises and health emergencies, including steps to reinforce WHO's leadership and coordination of the Inter-Agency Standing Committee Global Health Cluster and its complementarity to other humanitarian actors, taking into account the recommendations of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme;

(24) to strengthen WHO's communications to Member States in advance of and during public health emergencies, including through governing bodies meetings, the use of Member State briefings, and complementary communications as appropriate to Member States' national focal points;

(25) to strengthen effective, representative and transparent governance, communication and oversight mechanisms, including by strengthening engagement with the Executive Board, in order to enable Member States to provide informed guidance to WHO's work, especially during health emergencies, while ensuring participation of Member States in all aspects of international health protection;

(26) to strengthen WHO's efforts to prevent and address sexual exploitation and abuse and sexual harassment, including in humanitarian emergencies when sexual exploitation and abuse and sexual harassment may be at greater risk of occurring;

(27) to review and, as appropriate clarify, in consultation with Member States, the roles, nomination procedures and mandates of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme, the Global Preparedness Monitoring Board and other relevant entities dealing with WHO emergency preparedness and response;

(28) to continue efforts to respond to the recommendations of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme and integrate them as appropriate into the systems, structures, planning, working methods and organizational culture of the WHO Health Emergencies Programme and WHO more broadly, including into the gender- and geographical-balance approach;

(29) to extend the mandate of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme to 2023 and consider steps to further strengthen its mandate based on the review;

(30) to support the work of the Working Group on Sustainable Financing, established by the Executive Board at its 148th session, as an integral element of the process of strengthening WHO,

and at the same time, increase the financial transparency and accountability at all levels of the Organization and based on the outcomes of its work:

- (i) increase efforts to broaden the donor base, including through the COVID-19 Solidarity Response Fund and the WHO Foundation, while ensuring transparency and accountability and full Member States' oversight of the process;
 - (ii) assess the role and strategy of the Contingency Fund for Emergencies, and consider implementing a sustainable financing and replenishment mechanism for it in coordination with the relevant funding mechanisms, including the World Bank's Pandemic Emergency Financing Facility, in responding to health emergencies;
- (31) to support the Member States Working Group on Strengthening WHO preparedness and response to health emergencies, by:
- (i) convening its first meeting no later than 17 September 2021, announcing the date of that first meeting no later than 30 July 2021 and convening it thereafter at the request of the Member States Working Group Bureau as frequently as necessary;
 - (ii) providing complete, relevant and timely information to the Working Group for its discussions;
 - (iii) allocating the necessary resources for the Working Group to carry out its mandate, and providing information on anticipated costs and source of funding;
- (32) to submit a report on the implementation of this resolution to the Seventy-fifth World Health Assembly in 2022, through the Executive Board at its 150th session.

(Seventh plenary meeting, 31 May 2021
Committee B, fourth report)

WHA74.8 The highest attainable standard of health for persons with disabilities¹

The Seventy-fourth World Health Assembly,

Having considered the consolidated report by the Director-General;²

Recalling resolutions WHA58.23 (2005) on disability, including prevention, management and rehabilitation, WHA66.9 (2013) on disability, WHA67.7 (2014) on the WHO global disability action plan 2014–2021: better health for all people with disability, WHA71.8 (2018) on improving access to assistive technology and WHA72.3 (2019) on community health workers delivering primary health care: opportunities and challenges;

Recalling also the *World report on disability 2011* and the WHO global disability action plan 2014–2021,³ which is based on that report's recommendations;

¹ See Annex 4 for the financial and administrative implications for the Secretariat of this resolution.

² Document A74/9.

³ WHO global disability action plan 2014–2021: better health for all people with disability. Geneva: World Health Organization; 2015 (<https://apps.who.int/iris/handle/10665/199544>, accessed 28 June 2021).

Further recalling the United Nations Convention on the Rights of Persons with Disabilities,¹ which refers to persons with disabilities as including those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others, and under which 182 States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability;

Recognizing that disability is an evolving concept and that it results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others;

Recalling the 2030 Agenda for Sustainable Development and its aim of leaving no one behind, and the United Nations flagship *Disability and development report: realizing the Sustainable Development Goals by, for and with persons with disabilities 2018*,² presenting an overview of the status of accessibility for persons with disabilities, and the persistent gaps in this regard, and identified best practices and recommended action in accessibility for the effective implementation of the Convention on the Rights of Persons with Disabilities and the disability-inclusive achievement of the Sustainable Development Goals;

Recalling also the endorsement by the Fifty-fourth World Health Assembly of the International Classification of Functioning, Disability and Health in 2001;

Welcoming progress towards mainstreaming disability, including the rights of persons with disabilities in the work of the United Nations, and noting with appreciation the launch of the United Nations Disability Inclusion Strategy, which provides the foundation for sustainable and transformative progress on disability inclusion through the work of the United Nations;

Recognizing that persons with disabilities are disproportionately affected by public health emergencies, including pandemics such as coronavirus disease (COVID-19), and thus welcoming the specific guidance presented by the United Nations and WHO to advise relevant stakeholders on ways to mitigate the effects of the COVID-19 pandemic on persons with disabilities;

Recognizing also the need to include the experiences and perspectives of persons with disabilities and their representative organizations in all issues, including by taking steps to ensure and actively facilitate their meaningful participation in programmes, policy and decision-making processes;

Noting that globally one in seven persons experience some form of disability and that this number continues to increase owing to many underlying factors such as population ageing and the rise in the prevalence of chronic health conditions;

Noting also the persisting attitudinal, institutional and environmental barriers, including discriminatory attitudes towards disability and inaccessible communities;

Also noting, with concern, that persons with disabilities face persistent inequality in social, economic, health and political spheres, and thus are more likely to live in poverty than persons without disabilities; and that they are more likely to have risk factors for noncommunicable diseases; as well as being more likely to be unable to get access to essential health services, public health functions,

¹ United Nations General Assembly resolution 61/106 (2006).

² Disability and development report: realizing the Sustainable Development Goals by, for and with persons with disabilities, 2018. New York (NY): United Nations; 2019 (<https://social.un.org/publications/UN-Flagship-Report-Disability-Final.pdf>, accessed 17 January 2021).

medicines and treatment, due to environmental, financial, legal and attitudinal barriers in society, including discrimination and stigmatization, as well as lack of reliable and comparable data;

Further noting that, as many persons with disabilities face multiple and intersecting forms of discrimination and are therefore at greater risk of having unmet health needs, health and rehabilitation interventions should take into account different needs and be age-sensitive and gender-responsive while promoting, protecting and ensuring the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and promoting respect for their inherent dignity;

Recognizing that persons with disabilities are often disproportionately affected in situations of risk, including armed conflict and complex humanitarian emergencies, and in the occurrence of natural disasters and their aftermath, and that they may require specific protection and safety measures, recognizing also the need to support further participation and inclusion of persons with disabilities in the development of such measures and decision-making processes relating thereto, in order to ensure disability-inclusive risk reduction and humanitarian assistance, and recognizing the need for psychosocial support to withstand the effects of conflict and natural disasters;

Noting that many persons with disabilities, particularly girls and women, face barriers in accessing information and education, including with regard 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;

Noting also the urgent need to increase the availability of disaggregated data by disability in the health sector, and in other sectors, using internationally comparable high-quality disability data collection methods, in order to inform evidence-based health policies and programmes that are disability inclusive and meet the needs of persons with disabilities;

Noting further that persons with disabilities are an underrepresented group in health research, and that this in turn limits the application of research findings for their benefit;

Also noting that enabling universal access to assistive technology and rehabilitation services promotes the inclusion, participation and engagement of persons with disabilities in all areas of society;

Highlighting the role of community health workers in advancing equitable access of persons with disabilities to safe, quality, accessible, inclusive and innovative health services in urban and rural areas and in reducing inequities;

Stressing that disability-sensitive, quality, basic and continued education and training of health professionals, including effective communication skills, are crucial to ensure that they have the adequate professional skills and competencies in their respective roles and functions, to provide safe, quality, accessible and inclusive health services;

Stressing also that accessible health facilities, accessible health-related information and disability-specific health services and solutions are essential for persons with disabilities to benefit equally from health education, promotion, prevention, treatment and rehabilitation; and stressing further that technological solutions could be an effective means to enhance accessibility;

Underscoring that the health needs of persons with disabilities need to be met across the life course, through comprehensive preventive, promotive, curative, rehabilitative services and palliative care, including psychosocial support;

Reaffirming that health services should be provided to persons with disabilities on the basis of free and informed consent, and emphasizing that the necessary information to exercise such consent must be transmitted in a reasonable, accessible and understandable manner, to the extent possible,

1. URGES Member States:¹

(1) to incorporate a disability- and gender-sensitive and inclusive approach, including by closely consulting with and actively involving persons with disabilities and their representative organizations, in decision-making and designing programmes in order that they receive: effective health services as part of universal health coverage; equal protection during complex humanitarian emergencies and natural disasters and their aftermath; and equal access to cross-sectoral public health interventions, such as provision of safe water, sanitation and hygiene services, to achieve the highest attainable standard of health;

(2) to identify and eliminate attitudinal, environmental and institutional obstacles and barriers that prevent persons with disabilities from accessing health, including sexual and reproductive health care services, as well as health-related information, skills and goods, including by making health facilities accessible, by training relevant professionals on the human rights, dignity, autonomy and needs of persons with disabilities, by making information available in accessible formats, and by providing appropriate measures for the exercise of legal capacity in health-related issues;

(3) to develop, implement and strengthen policies and programmes, as appropriate, to improve access to rehabilitation, as well as affordable and quality assistive technology within universal health and/or social services coverage, and to ensure their sustainability;

(4) to collect health-related data, disaggregated by disability, age and sex, education level and household income to inform relevant policies and programmes;

(5) without discrimination on the basis of disability, to provide health services and care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent, respecting the human rights, dignity, autonomy, legal capacity and needs of persons with disabilities, including through training and the promulgation of ethical standards for public and private health care;

(6) to take measures to ensure comprehensive, accessible and affordable access to health systems and care for all persons with disabilities, while recognizing the unique vulnerabilities of those who may be living in care and congregated living settings in times of public health emergencies such as COVID-19, and for special protection against infections in particular for at-risk groups, with protection to include facilitating the education of health and care workers in the area of infection prevention and control to protect all persons with disabilities, whether living in the community or in care and congregated living settings;

2. INVITES international organizations and other relevant stakeholders, including intergovernmental and nongovernmental organizations, private-sector companies, academic institutions and, in particular, organizations of persons with disabilities:

(1) to collaborate with Member States in respecting, protecting and fulfilling the right to the enjoyment of the highest attainable standard of health of persons with disabilities;

¹ And, where appropriate, regional economic integration organizations.

- (2) to forge partnerships and alliances that mobilize and share knowledge and best practices on disability inclusion;
- (3) to amplify the voices of persons with disabilities and their representative organizations, and raise awareness of the rights, capabilities and contributions of persons with disabilities;
- (4) to include persons with disabilities in health research so that they benefit from its outcomes and products;

3. REQUESTS the Director-General:

- (1) to develop, in close consultation with Member States¹ and relevant international organizations and other stakeholders, by the end of 2022, a global report on the highest attainable standard of health for persons with disabilities, to be submitted for consideration by the Seventy-sixth World Health Assembly, through the Executive Board at its 152nd session, that addresses effective access and quality health services, including universal health coverage (with rehabilitation as part of it), health emergencies and health and well-being, that is based on the best available evidence, and that includes actionable recommendations; as well as to update the WHO estimates of the global disability prevalence presented in the *World report on disability 2011*;
- (2) to fully implement the United Nations Disability Inclusion Strategy across all levels of WHO in order to ensure that disability considerations, including the rights of persons with disabilities, are mainstreamed and systematically integrated in all programme areas and policy work, as well as in operations, including in emergency preparedness and response plans and in building and reconstruction planning, and transmit to the Executive Board a copy of the annual progress report on the implementation of the United Nations Disability Inclusion Strategy;
- (3) to support the creation of a global research agenda that aligns with universal health coverage, health emergencies and health and well-being, including health systems and policy research, and to explore possible ways to track progress on disability inclusion in the health sector towards 2030;
- (4) to provide Member States with the technical knowledge and capacity-building support necessary to incorporate a disability-sensitive and inclusive approach in accessing quality health services, protection during health emergencies and cross-sectoral public health interventions, in order to enable persons with disabilities to enjoy the highest attainable standard of health, including with regards to the support they may require in exercising their legal capacity in health-related issues; and to provide support to countries in collecting, processing, analysing and disseminating data on disability, including disaggregating data by disability, sex and age, and other characteristics relevant in national contexts, in collaboration with relevant stakeholders, and in close consultation with persons with disabilities and their representative organizations.

(Seventh plenary meeting, 31 May 2021
Committee B, second report)

¹ And, where appropriate, regional economic integration organizations.

WHA74.9 Recommitting to accelerate progress towards malaria elimination¹

The Seventy-fourth World Health Assembly,

Having considered the report on the global technical strategy and targets for malaria 2016–2030;²

Recalling resolutions WHA58.2 (2005) on malaria control, WHA60.18 (2007) and WHA64.17 (2011) on malaria, including the proposal for establishment of World Malaria Day, and United Nations General Assembly resolution 69/325 (2015) on consolidating gains and accelerating efforts to control and eliminate malaria in developing countries, particularly in Africa, by 2015 and beyond, and resolutions 70/300 (2016), 71/325 (2017), 72/309 (2018), 73/337 (2019) and 74/305 (2020) on consolidating gains and accelerating efforts to control and eliminate malaria in developing countries, particularly in Africa, by 2030 and resolution WHA68.2 (2015) on the global technical strategy and targets for malaria 2016–2030;

Noting the report of the WHO Strategic Advisory Group on Malaria Eradication entitled Malaria eradication: benefits, future scenarios and feasibility;

Noting with concern that two of the four global technical strategy for malaria 2016–2030 milestones for 2020 were not met, as reported in the *World malaria report 2020*, as the world has not been successful in reducing malaria mortality rates globally by 40% or in reducing malaria case incidence globally by 40%, compared with 2015 baselines, while welcoming the realization of country-level milestones on achieving national elimination in 10 countries and preventing re-establishment of malaria in all countries that were malaria free;

Recognizing that sustainable, equitable malaria control requires resilient health systems and the achievement of universal health coverage, and that the ongoing coronavirus disease (COVID-19) pandemic and other recent past epidemics have negatively affected health systems' functioning and the production and delivery of life-saving malaria interventions in environments safe for both health workers and communities;

Taking into account the 1955 resolution WHA8.30 on malaria eradication, in which the Eighth World Health Assembly decided “that the World Health Organization should take the initiative, provide technical advice, and encourage research and co-ordination of resources in the implementation of a programme having as its ultimate objective the world-wide eradication of malaria” and acknowledging the 2016 African Union's Catalytic framework to end AIDS, TB and eliminate malaria in Africa by 2030 and the 2015 East Asia Summit commitment to eliminate malaria across Asia Pacific,

1. RECOMMITS to the goal of malaria eradication and affirms that this goal will be incorporated into the post-2030 iteration of the global technical strategy for malaria;
2. ADOPTS the updated global technical strategy for malaria 2016–2030,³ which emphasizes country ownership and promotes equitable and resilient health systems to deliver quality services, which are adaptive to local situations and which recognizes the need for capacity-strengthening so that countries can generate, analyse and use high-quality data, including surveillance data, for making decisions and tailoring responses to leave no one behind so that countries can improve the effectiveness and quality of health services, introducing additional highly effective interventions into the existing

¹ See Annex 4 for the financial and administrative implications for the Secretariat of this resolution.

² Document A74/55.

³ Global technical strategy for malaria 2016–2030, 2021 update. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/342995>, accessed 17 September 2021).

package where this is cost-effective and aligned with country priorities; and better addressing the wider determinants that potentially disrupt or facilitate the reach and quality of services, particularly for women and children under 5 years of age;

3. URGES Member States:¹

(1) to accelerate the pace of implementation, according to national contexts and priorities and their malaria strategies and operational plans consistent with the updated framework and principles of the global technical strategy for malaria 2016–2030 and the WHO Guidelines for malaria;

(2) to extend investment in and support to health services, including integrated, accessible, affordable and quality prevention, detection, diagnosis and treatment including through the use of technology-based solutions at facility and community levels ensuring no one is left behind, including to improve access for the most rural remote and marginalized populations that have the lowest access and coverage of interventions;

(3) to sustain and scale up as appropriate, sufficient funding of the global response against malaria;

(4) to extend investment in the development of new tools and support for implementation research and innovation to enable efficient delivery and equitable access with a view to maximizing impact and cost-effectiveness;

4. URGES international, regional and national partners from within and beyond the health sector, in particular those in the Roll Back Malaria Partnership to End Malaria, to strengthen their support for and further engage in implementation of the global technical strategy for malaria 2016–2030 update and align this with existing health strategies and plans;

5. REQUESTS the Director-General:

(1) to continue to provide technical support and guidance to Member States¹ for the national adaptation, implementation and operationalization of the updated global technical strategy for malaria 2016–2030;

(2) to update regularly technical guidance on malaria prevention, care and control and elimination, as new evidence is gathered and innovative tools and approaches become available and support countries to adopt and implement this guidance effectively;

(3) to monitor the implementation of the updated global technical strategy for malaria 2016–2030 and evaluate its impact in terms of progress towards set milestones and targets;

(4) to work with Member States,¹ civil society and other partners to increase investment in and efforts towards research to optimize current tools, develop and validate new, safe and affordable malaria-related medicines, products and technologies, including the R&D blueprint, and foster the generation, translation and dissemination of normative, technical and operational guidance;

¹ And, where applicable, regional economic integration organizations.

(5) to submit a status report to the Seventy-seventh World Health Assembly in 2024, and a full progress report to the Seventy-ninth World Health Assembly in 2026, followed by a final status report to the Eighty-first World Health Assembly in 2028.

(Seventh plenary meeting, 31 May 2021 –
Committee B, second report)

WHA74.10 Salaries of staff in ungraded positions and of the Director-General

The Seventy-fourth World Health Assembly,

Having considered the consolidated report by the Director-General;¹

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

1. ESTABLISHES the salaries of Assistant Directors-General and Regional Directors at US\$ 186 323 gross per annum with a corresponding net salary of US\$ 138 473;
2. ESTABLISHES the salary of the Deputy Director-General at US\$ 205 264 gross per annum with a corresponding net salary of US\$ 150 974;
3. ESTABLISHES the salary of the Director-General at US\$ 257 010 gross per annum with a corresponding net salary of US\$ 193 407;
4. DECIDES that those adjustments in remuneration shall take effect from 1 January 2021.

(Seventh plenary meeting, 31 May 2021 –
Committee B, second report)

WHA74.11 Agreement between the World Health Organization and the International Organisation of La Francophonie

The Seventy-fourth World Health Assembly,

Having considered the report on the proposed agreement between the World Health Organization and the International Organisation of La Francophonie;³

Considering also Article 70 of the Constitution of the World Health Organization,

APPROVES the proposed agreement between the World Health Organization and the International Organisation of La Francophonie.⁴

(Seventh plenary meeting, 31 May 2021 –
Committee B, second report)

¹ Document A74/9.

² See document EB148/45; see also the summary records of the Executive Board at its 148th session, eleventh meeting, section 4.

³ Document A74/44.

⁴ Annex 1.

WHA74.12 Participation of the Holy See in the World Health Organization

The Seventy-fourth World Health Assembly,

Recalling that the Holy See has been regularly attending the sessions of the Health Assembly as an Observer since 1953;

Recalling also that the Holy See has been regularly attending the sessions of the Executive Board as an Observer;

Recalling further that the Holy See has been a Permanent Observer State at the United Nations since 1964 and that its rights and privileges of participation in the General Assembly as well as in other meetings and conferences of the United Nations were specified by United Nations General Assembly resolution 58/314 of 1 July 2003;

Noting that the Holy See enjoys membership in various United Nations subsidiary bodies, specialized agencies and international intergovernmental organizations, including the Executive Committee of the Programme of the United Nations High Commissioner for Refugees, the United Nations Conference on Trade and Development, the World Intellectual Property Organization, the International Organization for Migration, the International Atomic Energy Agency, the Organisation for the Prohibition of Chemical Weapons, the Preparatory Commission for the Comprehensive Nuclear-Test-Ban Treaty Organization and the International Committee of Military Medicine;

Noting also that the Holy See is an Observer State in various United Nations subsidiary bodies, specialized agencies and international intergovernmental organizations, including the United Nations Office on Drugs and Crime, the World Food Programme, the United Nations Development Programme, the United Nations Environment Programme, the United Nations Settlements Programme and the United Nations Children's Fund, the Food and Agriculture Organization of the United Nations, the International Labour Organization, the United Nations Educational, Scientific and Cultural Organization, the United Nations Industrial Development Organization, the International Fund for Agricultural Development, the World Tourism Organization, the World Meteorological Organization, as well as in the World Trade Organization;

Noting further that the Holy See became a State Party to the International Health Regulations (2005) on 15 June 2007,

DECIDES that the Holy See, in its capacity as a non-Member State Observer, shall be accorded in the sessions and work of the Health Assembly, the Executive Board and the Programme, Budget and Administration Committee of the Executive Board, the rights and privileges of participation set forth in Annex 2.

(Seventh plenary meeting, 31 May 2021 –
Committee B, second report)

WHA74.13 Scale of assessments 2022–2023

The Seventy-fourth World Health Assembly,

Having considered the report by the Director-General on the scale of assessments for 2022–2023;¹

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

ADOPTS the scale of assessments of Members and Associate Members for the biennium 2022–2023 as set out below.

Members and Associate Members	WHO scale for 2022–2023 %
Afghanistan	0.0070
Albania	0.0080
Algeria	0.1380
Andorra	0.0050
Angola	0.0100
Antigua and Barbuda	0.0020
Argentina	0.9151
Armenia	0.0070
Australia	2.2101
Austria	0.6770
Azerbaijan	0.0490
Bahamas	0.0180
Bahrain	0.0500
Bangladesh	0.0100
Barbados	0.0070
Belarus	0.0490
Belgium	0.8211
Belize	0.0010
Benin	0.0030
Bhutan	0.0010
Bolivia (Plurinational State of)	0.0160
Bosnia and Herzegovina	0.0120
Botswana	0.0140
Brazil	2.9482
Brunei Darussalam	0.0250
Bulgaria	0.0460
Burkina Faso	0.0030
Burundi	0.0010
Cabo Verde	0.0010
Cambodia	0.0060
Cameroon	0.0130

¹ Document A74/32.

² Document A74/49.

Members and Associate Members	WHO scale for 2022–2023 %
Canada	2.7342
Central African Republic	0.0010
Chad	0.0040
Chile	0.4070
China	12.0058
Colombia	0.2880
Comoros	0.0010
Congo	0.0060
Cook Islands (not a member of the United Nations)	0.0010
Costa Rica	0.0620
Côte d'Ivoire	0.0130
Croatia	0.0770
Cuba	0.0800
Cyprus	0.0360
Czech Republic	0.3110
Democratic People's Republic of Korea	0.0060
Democratic Republic of the Congo	0.0100
Denmark	0.5540
Djibouti	0.0010
Dominica	0.0010
Dominican Republic	0.0530
Ecuador	0.0800
Egypt	0.1860
El Salvador	0.0120
Equatorial Guinea	0.0160
Eritrea	0.0010
Estonia	0.0390
Eswatini	0.0020
Ethiopia	0.0100
Fiji	0.0030
Finland	0.4210
France	4.4273
Gabon	0.0150
Gambia	0.0010
Georgia	0.0080
Germany	6.0904
Ghana	0.0150
Greece	0.3660
Grenada	0.0010
Guatemala	0.0360
Guinea	0.0030
Guinea-Bissau	0.0010
Guyana	0.0020
Haiti	0.0030
Honduras	0.0090
Hungary	0.2060

Members and Associate Members	WHO scale for 2022–2023 %
Iceland	0.0280
India	0.8341
Indonesia	0.5430
Iran (Islamic Republic of)	0.3980
Iraq	0.1290
Ireland	0.3710
Israel	0.4900
Italy	3.3072
Jamaica	0.0080
Japan	8.5645
Jordan	0.0210
Kazakhstan	0.1780
Kenya	0.0240
Kiribati	0.0010
Kuwait	0.2520
Kyrgyzstan	0.0020
Lao People's Democratic Republic	0.0050
Latvia	0.0470
Lebanon	0.0470
Lesotho	0.0010
Liberia	0.0010
Libya	0.0300
Lithuania	0.0710
Luxembourg	0.0670
Madagascar	0.0040
Malawi	0.0020
Malaysia	0.3410
Maldives	0.0040
Mali	0.0040
Malta	0.0170
Marshall Islands	0.0010
Mauritania	0.0020
Mauritius	0.0110
Mexico	1.2921
Micronesia (Federated States of)	0.0010
Monaco	0.0110
Mongolia	0.0050
Montenegro	0.0040
Morocco	0.0550
Mozambique	0.0040
Myanmar	0.0100
Namibia	0.0090
Nauru	0.0010
Nepal	0.0070
Netherlands	1.3561
New Zealand	0.2910

Members and Associate Members	WHO scale for 2022–2023 %
Nicaragua	0.0050
Niger	0.0020
Nigeria	0.2500
Niue (not a member of the United Nations)	0.0010
North Macedonia	0.0070
Norway	0.7540
Oman	0.1150
Pakistan	0.1150
Palau	0.0010
Panama	0.0450
Papua New Guinea	0.0100
Paraguay	0.0160
Peru	0.1520
Philippines	0.2050
Poland	0.8021
Portugal	0.3500
Puerto Rico (not a member of the United Nations)	0.0010
Qatar	0.2820
Republic of Korea	2.2671
Republic of Moldova	0.0030
Romania	0.1980
Russian Federation	2.4052
Rwanda	0.0030
Saint Kitts and Nevis	0.0010
Saint Lucia	0.0010
Saint Vincent and the Grenadines	0.0010
Samoa	0.0010
San Marino	0.0020
Sao Tome and Principe	0.0010
Saudi Arabia	1.1721
Senegal	0.0070
Serbia	0.0280
Seychelles	0.0020
Sierra Leone	0.0010
Singapore	0.4850
Slovakia	0.1530
Slovenia	0.0760
Solomon Islands	0.0010
Somalia	0.0010
South Africa	0.2720
South Sudan	0.0060
Spain	2.1461
Sri Lanka	0.0440
Sudan	0.0100
Suriname	0.0050

Members and Associate Members	WHO scale for 2022–2023 %
Sweden	0.9061
Switzerland	1.1511
Syrian Arab Republic	0.0110
Tajikistan	0.0040
Thailand	0.3070
Timor-Leste	0.0020
Togo	0.0020
Tokelau (not a member of the United Nations)	0.0010
Tonga	0.0010
Trinidad and Tobago	0.0400
Tunisia	0.0250
Turkey	1.3711
Turkmenistan	0.0330
Tuvalu	0.0010
Uganda	0.0080
Ukraine	0.0570
United Arab Emirates	0.6160
United Kingdom of Great Britain and Northern Ireland	4.5673
United Republic of Tanzania	0.0100
United States of America	22.0000
Uruguay	0.0870
Uzbekistan	0.0320
Vanuatu	0.0010
Venezuela (Bolivarian Republic of)	0.7280
Viet Nam	0.0770
Yemen	0.0100
Zambia	0.0090
Zimbabwe	0.0050
TOTAL	100.000

(Seventh plenary meeting, 31 May 2021 –
Committee B, third report)

WHA74.14 Protecting, safeguarding and investing in the health and care workforce¹

The Seventy-fourth World Health Assembly,

Having considered the Director General's report on working for health: five-year action plan for health employment and inclusive economic growth (2017–2021);²

¹ See Annex 4 for the financial and administrative implications for the Secretariat of this resolution.

² Document A74/12.

Deeply concerned about the detrimental impact that coronavirus disease (COVID-19) has had across the health and social care sectors;

Expressing highest appreciation of, and support for, the dedication, efforts and sacrifices, above and beyond the call of duty of health professionals, health workers and other relevant frontline workers in responding to the COVID-19 pandemic;

Recalling decision WHA73(30) (2020) to designate 2021 as the International Year of Health and Care Workers;

Guided by the 2030 Agenda for Sustainable Development, including its strong multisectoral dimension to achieve universal health coverage, and its call in Sustainable Development Goal 3, target 3.c to “substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States”;

Recognizing the need for political commitment, policies and international cooperation, including strong Sustainable Development Goal partnerships at national, regional and global levels, to tackle health inequities and inequalities within and among countries, in line with non-discriminatory laws, and including within the health and care workforce, and how health workforce constraints impact equity of service delivery;

Recognizing the twenty-fifth anniversary of the Beijing Declaration and Platform for Action marked by the Generation Equality Forum, and the Gender Equal Health and Care Workforce Initiative, to advance equity for women in the health and care sector that acknowledges a pivotal moment for the realization of gender equality and the empowerment of all women and girls, everywhere;

Recalling the Political Declaration of the United Nations high-level meeting on universal health coverage with commitments to scale up efforts to promote the recruitment and retention of competent, skilled and motivated health and care workers, and to secure equitable distribution in rural, hard-to-reach areas, including by providing decent and safe working conditions and appropriate remuneration;

Acknowledging the agreed conclusions and recommendations adopted by the Economic and Social Council forum on financing for development follow-up in April 2021, which underscore that investments in resilient health infrastructure, health systems and universal health coverage, aligned with the 2030 Agenda for Sustainable Development, are key to sustainable development and alleviating poverty, and which resolved to take action to prioritize spending, among others, on essential health functions and social protection measures;

Recognizing that primary health care is the cornerstone of a sustainable health system for universal health coverage, requiring a multidisciplinary team of health and care workers;

Recognizing the fifth anniversary of United Nations Security Council resolution 2286 (2016) on protection of the wounded and sick, medical personnel and humanitarian personnel in armed conflict, and acknowledging resolution WHA70.6 (2017), which recognized the need to substantially increase the protection and security of health and social workers and health facilities in all settings, including in acute and protracted public health emergencies and humanitarian settings;

Further recalling resolution WHA63.16 (2010) on the WHO Global Code of Practice on the International Recruitment of Health Personnel, which adopted the Global Code, and the Global Code’s recognition that an adequate and accessible health workforce is fundamental to an integrated and effective health system, and to the provision of health services, bearing in mind the necessity of

mitigating the negative effects of health personnel migration on health systems, particularly of developing countries;

Bearing in mind the recommendations of the Report of the WHO Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel on the need for the full implementation of the Global Code as well as health workforce- and health systems-related support and safeguards through strengthened international cooperation, particularly to countries facing the greatest challenges;

Reaffirming resolution WHA69.19 (2016) on the global strategy on human resources for health: workforce 2030 and its objectives to expand and transform the recruitment, development, education, training, distribution, retention and financing of the health and care workforce;

Also acknowledging the call for progressive implementation of national health workforce accounts in resolution WHA69.19 (2016) in order to strengthen the availability, quality and completeness of health workforce data, further underscored by the COVID-19 pandemic response;

Recalling United Nations General Assembly resolution 71/159 (2016), which underlines that health workers are the cornerstone of a resilient health system and that the domestic health workforce is the primary responder in all countries, including those with fragile health systems, and is key to building resilient health systems with the objective to achieve universal health coverage, and which urged Member States to consider the recommendations of the United Nations High-Level Commission on Health Employment and Economic Growth, including the development of intersectoral plans and investment in education and job creation in the health and social sectors, recognizing that provision of decent work opportunities and career pathways, particularly for young people and women, is fundamental for inclusive and sustainable economic and social recovery; and thereafter resolution WHA70.6 (2017), which adopted the Working for Health five-year action plan mechanism;

Acknowledging resolution WHA69.1 (2016), which urged Member States to invest in the education, training, recruitment and retention of a fit-for-purpose and responsive public health and care workforce that is effectively and equitably deployed to contribute to effective and efficient delivery of essential public health functions based on population needs;

Recalling United Nations General Assembly resolution 75/157 (2020) on women and girls and the response to the coronavirus disease (COVID-19) and emphasizing the critical role that women, who represent almost 70% of health workers, play in the context of the COVID-19 pandemic;

Recalling WHA73.1 (2020) on COVID-19 response, which calls on Member States, in the context of the COVID-19 pandemic, to provide health professionals, health and care workers and other relevant frontline workers, including humanitarian workers with heightened risk of exposure to the virus causing COVID-19, with access to personal protective equipment and other necessary commodities and training, including through the provision of psychosocial support; and to take immediate measures for their protection at work, facilitating their access to work and ensuring their adequate remuneration;

Acknowledging that the physical and mental health and well-being of health and care workers is impacted by health worker and skills shortages that can contribute to increased stress, workload, and burnout, and decreased health worker productivity, performance and retention – resulting in enduring effects on the functioning, efficiency and resiliency of health systems; and concerned that the world, if the current trends continue, could suffer from a projected shortfall of 18 million health workers in 2030, primarily in low- and lower-middle-income countries;

Noting the disruptions to pre-service education and life-long learning as a result of the COVID-19 pandemic and the increased demand for digital, competency-based education to provide all health and care workers with sufficient access to evidence, quality education and learning;

Noting the essential role of the research response during the COVID-19 pandemic, including implementation science, the importance of basic and clinical research, the translation of research into evidence-based strategies, the role of public health researchers in the early detection, response and recovery efforts to health emergencies and support for the mental and psychosocial well-being of health and care workers,

1. CALLS ON Member States, in accordance with national context and priorities:¹

(1) to continue implementation of the Global Strategy on Human Resources for Health: Workforce 2030, including through the Global Health Workforce Network, including:

(i) to advance the health and care workforce investment agenda, with a special focus on the primary health care workforce in order to accelerate universal health coverage;

(ii) to accelerate measurement, monitoring and reporting, at an appropriate frequency, to support national workforce planning based on disaggregated demographic data, including sex and other characteristics, on the health and care workforce through further implementation of national health workforce accounts to ensure sufficient number, distribution, competency, utilization, employment, safeguarding and protection of health and care workers, including the capacity and readiness of the health and care workforce to provide strong integrated public health functions to strengthen preparedness, prevention, detection and response to health emergencies and support the implementation of the International Health Regulations (2005);

(iii) to carry out an assessment of health and care workforce implications and requirements in all health policies, strategies, plans and programmes to ensure sustained support and investment, optimal utilization of available workers across public and private sectors, coordinated leadership, enhanced workforce performance, and a safe workplace and practice environment;

(iv) to continue to implement the WHO Global Code of Practice on the International Recruitment of Health Personnel and the recommendations of the WHO Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel in 2020,² to equitably strengthen health systems worldwide, to mitigate the negative effects of health personnel migration and to safeguard the rights of all health personnel, with particular attention to the 47 countries identified on the WHO Health Workforce Support and Safeguards List (2020), and to report triennially to the Health Assembly, through the Executive Board, on the Global Code's implementation, including data on international health workforce migration, such as the level and country of the professional examination data from health personnel information systems, and measures taken, results achieved and difficulties encountered in implementing the Global Code;

¹ And, as appropriate, regional economic integration organizations.

² See document A73/9.

- (v) to facilitate national and subnational capacity for an effective intersectoral coordination mechanism to manage health and care workforce agendas;
- (2) to engage relevant sectors and promote intersectoral mechanisms at the subnational, national and regional levels as appropriate for efficient investment in and effective implementation of health workforce policies, using a gender-based and inclusive approach;
- (3) to prioritize investments and the efficient and effective use of sustained domestic and international financing for the recruitment and retention, education and training, skills, jobs, safeguarding and protection needed to build resilient health systems capacities, competencies and capabilities, through a health and care workforce that is equitably distributed, deployed, utilized, retained, empowered, protected and supported to deliver national priorities and targets for population health, to contribute to better understanding and managing of health worker migration through improved data and information for the achievement of universal health coverage, and for the effective implementation of essential public health functions;
- (4) to develop, finance, implement, monitor, specifying the method, national health and care workforce strategies and investment plans in line with population health needs now and in the future, and job, skills and education and training opportunities, with specific attention to equity, gender, diversity and inclusion in the health and care sector;
- (5) to enrich the career paths open to health and care workers in all countries by encouraging the development of both laboratory capabilities for diagnosis and surveillance and research programmes that combine local knowledge with up-to-date scientific understanding and methodology;
- (6) to take the necessary steps to safeguard and protect health and care workers at all levels, through the equitable distribution of personal protective equipment, therapeutics, vaccines and other health services, effective infection prevention control and occupational safety and health measures within a safe and enabling work environment that is free from racial and all other forms of discrimination;
- (7) to recognize and condemn increasing incidents of attacks against health and care workers, including those attacks that are motivated by fear and stigma associated with COVID-19, and fully comply with their obligations under international law, including international human rights law, as applicable, and international humanitarian law¹ and implement the existing international legal framework for protecting the provision of and access to health care in armed conflicts and other emergencies, including the current COVID-19 pandemic;
- (8) to provide equitable access to vaccines, therapeutics and diagnostics, including for all health and care workers at the forefront of the COVID-19 response and other future outbreaks, epidemics and pandemics; and ensure their personal protection and safeguarding through relevant occupational health and safety and infection prevention and control guidelines and measures;^{2,3}

¹ See United Nations Security Council resolution 2286 (2016).

² COVID-19: Occupational health and safety for health workers. Interim guidance, 2 February 2021. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/339151>, accessed 30 June 2021).

³ Health workforce policy and management in the context of the COVID-19 pandemic response: interim guidance, 3 December 2020. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/337333>, accessed 30 June 2021).

(9) to support, with due respect for collective bargaining, decent work, working conditions, pay equity and other labour protections, promote respect for fundamental principles and rights at work, for all health and care workers, and support the prevention of violence, discrimination and harassment, including sexual harassment against health and care workers, the majority of whom (almost 70%) are women, and create opportunities for women in the health and care workforce, that support their full and meaningful participation and representation, including in senior leadership and decision-making roles;

2. INVITES international, regional, and national partners and stakeholders to engage in and support the catalytic investment, protection and safeguarding of the health and care workforce, through a coordinated national workforce investment agenda and action plan, specifically calling for:

(1) relevant global health initiatives and partners to invest in human resources for health and in health and care workforce readiness, education, training, skills and competencies, including to manage the current pandemic and strengthen provision of uninterrupted essential health services; and build capacities for health preparedness and response;

(2) professional associations, councils, regulatory bodies, trade unions, civil society, the private sector and political leaders to mobilize collective action and advocacy for supporting investments in health and care workforce job creation, skills, education and training; to invest in national education centres, including but not limited to collaboration with the WHO Academy, safeguarding and protection; and to highlight the critical role of health and care workers in accelerating economic recovery, health systems strengthening, societal well-being and social protection;

(3) international financing institutions, regional development banks and other public and private financing institutions to supplement domestic financing for health workforce and to support prioritized sustainable, scalable catalytic investment in education, skills and jobs in the health and care sectors as part of economic recovery, and to build preparedness, readiness and health systems capabilities to align their health and care workforce investments and contributions with the Working for Health Multi-Partner Trust Fund mechanism;

(4) bilateral and multilateral partners and financing institutions to integrate and provide medium- to long-term catalytic funding support to ensure sustained levels of investment in the health and care workforce and health systems;

(5) all partners to support WHO's efforts on the International Year of Health and Care Workers, and to join its campaign to #Protect, #Invest, #Together, as well as the Gender Equal Health and Care Workforce Initiative;

3. REQUESTS the Director-General:

(1) to implement the recommendations in the Director-General's report to the Seventy-fourth World Health Assembly on working for health: five-year action plan for health employment and inclusive economic growth (2017–2021), including:

(i) to develop through a Member State-led process, a clear set of actions, a 2022–2030 agenda and implementation mechanism to be presented to the Seventy-fifth World Health Assembly in 2022, for accelerating investments in health and care worker education, skills, jobs, safeguarding and protection, building on the joint support of WHO, ILO and OECD and the existing Working for Health Multi-Partner Trust Fund;

- (ii) to develop recommendations for strengthening the Working for Health Multi-Partner Trust Fund mechanism and its ability to engage with international financing institutions to leverage sustainable and innovative financing for all aspects of the multisectoral health and care workforce agenda and action plan: 2022–2030;
 - (iii) to support Member States, upon request, to implement the Global Strategy on Human Resources for Health: Workforce 2030 and to mobilize catalytic funding for investing in the workforce and health systems support needed to strengthen primary health care for achieving universal health coverage, including strong integrated public health functions to strengthen preparedness, prevention, detection and response to health emergencies, through the progressive implementation of a multisectoral health and care workforce agenda and action plan: 2022–2030, and with particular emphasis on promoting multisectoral policy dialogue and sectoral social dialogue, the application of quality reliable data and analysis for evidence-based decisions and investments, and resource mobilization;
- (2) to develop, in consultation with Member States, a succinct compilation document under the name of “global health and care worker compact”, following up on resolution WHA73.1 (2020) and decision WHA73(30) (2020), based on already existing documents of relevant international organizations (in any case WHO and ILO), which aims at providing Member States, stakeholders and relevant other organizations with technical guidance on how to protect health and care workers and safeguard their rights, and to promote and ensure decent work, free from racial and all other forms of discrimination and a safe and enabling practice environment, in line with the WHO Global Code of Practice on the International Recruitment of Health Personnel;
- (3) to facilitate cooperation between United Nations agencies and programmes, and other relevant global health initiatives and stakeholders, for aligning resourcing and investments with the multisectoral health and care workforce agenda and action plan: 2022–2030, and in particular for the effective implementation of national workforce strategies and plans, including strategies that address the specific challenges for hiring, training, supporting and protecting the health and care work force in public health, protracted emergencies and humanitarian settings;
- (4) to accelerate the health-related Sustainable Development Goals, the Thirteenth General Programme of Work, 2019–2023 and the COVID-19 response by supporting the health and care workforce with equitable access to competency-based education and lifelong learning, with innovative fit-for-purpose and digital learning, including on health emergency preparedness and response, through, but not limited to, the WHO Academy, as well as educational opportunities that can be offered by academic institutions, nongovernmental organizations and Member States;
- (5) to utilize and expand national health workforce accounts for accelerating the continuous measurement and monitoring of the number, status, skills, distribution, utilization, financing, safeguarding and protection of the health and care workforce, including the collection of data pertaining to health and care workers’ morbidity and mortality, in the context of their work responding to epidemics and/or pandemics, including quantifying and measuring the workforce needed for the provision of uninterrupted essential health services, public health functions and health emergency preparedness and response in line with the International Health Regulations (2005);
- (6) to encourage and support all Member States to report triennially on the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel, and urge Member States’ accountability, in accordance with national context and priorities, to their reporting commitments;

(7) to disseminate and encourage the use of information to address the international migration of health workforces;

(8) to submit a report to the Health Assembly on the progress made in implementing this resolution, integrated with reporting on the Global Strategy on Human Resources for Health: Workforce 2030 and aligned with the WHO Global Code of Practice on the International Recruitment of Health Personnel in 2022, 2025 and 2028.

(Seventh plenary meeting, 31 May 2021 –
Committee B, third report)

WHA74.15 Strengthening nursing and midwifery: investments in education, jobs, leadership and service delivery¹

The Seventy-fourth World Health Assembly,

Having considered the Director-General's report on the global strategic directions for nursing and midwifery 2021–2025;²

Recalling the Seventy-second World Health Assembly decision to designate 2020 as the International Year of the Nurse and the Midwife to increase appreciation of and investments in the nursing and midwifery workforces;

Commending the leadership, commitment and professionalism of nurses and midwives, who continue to provide essential health services and remain on the front line in the fight against the coronavirus disease (COVID-19) pandemic and in humanitarian emergencies;

Deeply concerned with the COVID-19 pandemic and the detrimental impact that this has had on health and care workers, including nurses and midwives who account for nearly 50% of the global health workforce;

Recognizing that protecting, safeguarding and investing in the health and care workforce is fundamental for building health systems resilience, maintaining essential health services and public health functions, including in preparing for, implementing and evaluating COVID-19 vaccine rollout, to enable economic and social recovery;

Recalling resolution WHA64.10 (2011) on strengthening national health emergency and disaster management capacities and the resilience of health systems, which recognizes the domestic health workforce as the primary responder in all countries, including those with fragile health systems, and is key to building resilient health systems that contribute to the achievement of the Sustainable Development Goals;

Reaffirming resolution WHA69.11 (2016) on health in the 2030 Agenda for Sustainable Development, which recognizes that health workers and the public health workforce are integral to building strong and resilient health systems that contribute to the achievement of the Sustainable Development Goals;

¹ See Annex 4 for the financial and administrative implications for the Secretariat of this resolution.

² Document A74/13.

Reaffirming resolution WHA69.19 (2016) on the global strategy on human resources for health: workforce 2030 and the objectives to expand and transform the development, education and training, distribution and retention of the health and care workforce especially nurses and midwives;

Noting the disruptions to education and life-long learning as a result of the global pandemic and the increased demand for digital, competency-based education to provide all nurses and midwives with sufficient access to evidence, quality education and learning;

Taking note of the Director-General's report detailing the shortage and maldistribution of the nursing and midwifery workforces, and the prominent inequities that are projected to remain until 2030 unless decisive action is taken to improve education, increase economic demand for the creation of jobs in particular in rural areas, develop nursing and midwifery leadership, and protect and enable nurses and midwives in their service delivery environments;

Recognizing that the COVID-19 pandemic has had a disproportionate impact on the poorest and the most vulnerable populations, with repercussions on health and development gains, in particular in developing countries, especially least developed countries and small island developing states, thus hampering the achievement of universal health coverage and the strengthening of primary health care;

Recognizing that primary health care is the corner-stone of a sustainable health system for universal health coverage, and that the health and care workforce is a fundamental pillar of primary health care;

Further recognizing the crucial contribution of the nursing and midwifery professions to strengthening health systems, to increasing access to comprehensive and patient-centred health services for the people they serve across the lifespan, mindful of cultural contexts, and to the efforts to achieve the internationally agreed health-related development goals, including the 2030 Agenda for Sustainable Development and those of WHO's programmes;

Recognizing the differences between nursing and midwifery and that while the two professions share many of the same challenges, they maintain their own specific scopes of practice;

Acknowledging that the health, well-being, lives and safety of nurses and midwives, particularly for those providing front-line services, were already affected by health workforce and skills shortages in many countries, and that this is further exacerbated by the COVID-19 pandemic, resulting in increased stress, strain and burn-out and reduced productivity and performance, and impacting workforce retention and therefore the functioning, efficiency and resilience of health systems;

Further acknowledging the importance shown by the COVID-19 pandemic of strengthening health worker protection and employees' well-being, including through tailored approaches for psychosocial support, additional training and support for new practices for recovery and continuous monitoring of employee well-being, and ensuring respectful work environments that are free from racial and all other forms of discrimination;

Concerned at the long-standing shortages and maldistribution of nurses and midwives in many countries, particularly in rural and remote settings, and the impact of this on health and development outcomes, which are inextricably linked, and recognizing the need for effective planning of the education, deployment and retention of health professionals – including through the collaboration of authorities responsible for health, education and employment – to educate, employ and retain an additional 5.7 million nurses and 750 000 midwives by the year 2030 in order to realize Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages);

Recalling the 2030 Agenda for Sustainable Development, including Sustainable Development Goal 3, target 3.8 on achieving universal health coverage and target 3.c to “substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States”;

Noting also with concern that factors negatively affecting the recruitment and retention of general and specialized nursing and midwifery personnel persist and have been exacerbated during the COVID-19 pandemic, thereby hindering the capacity of countries, in particular developing countries, especially least developed countries and small island developing States, to deliver efficient and effective quality health care and services;

Reaffirming the continuing importance of resolution WHA63.16 (2010) in applying the WHO Global Code of Practice on the International Recruitment of Health Personnel and the WHO Global Code’s recognition that an adequate and accessible health workforce is fundamental to an integrated and effective health system, and to the provision of health services;

Acknowledging that applying the WHO Global Code of Practice on the International Recruitment of Health Personnel is crucial to ensuring the proper and ethical management of international recruitment, and health personnel international migration, and that this can make a contribution to the development and strengthening of health systems, while bearing in mind the necessity of mitigating their impact in countries of origin;

Reiterating the importance of continued and concerted efforts, and the provision of development assistance; and further recognizing with deep concern, the impact of high debt levels on countries’ ability to withstand the impact of the COVID-19 shock;

Noting the specific needs and special circumstances of developing countries, especially least developed countries and small island developing States, and those in fragile, conflict-affected and vulnerable settings, due to their vulnerabilities and capacity constraints, and their need for sustained technical and financial assistance aimed at strengthening health systems, including nursing and midwifery workforce development;

Recognizing further the deliberations by Member States at the three High-Level Events on Financing for Development in the Era of COVID-19 and Beyond and the necessity to expand support for the most vulnerable, including through social and financial protection, and education and health systems, so that no one is left behind, as part of economic recovery at all levels;

Acknowledging the importance of initiatives that promote gender equality, such as the Beijing Platform for Action (Beijing +25), Generation Equality Forum and the Gender Equal Health and Care Workforce Initiative, bearing in mind that women account for 90% of the global nursing and midwifery workforce;

Mindful of previous resolutions to strengthen nursing and midwifery,¹ as well as previous global strategic directions on nursing and midwifery, including the most recent iteration for 2016–2020;

Recalling also decision WHA73(30) (2020), which requested the Director-General to update the *Global Strategic Directions for Nursing and Midwifery 2016–2020* and submit the update to the Seventy-fourth World Health Assembly for its consideration;

¹ Resolutions WHA42.27 (1989), WHA45.5 (1992), WHA49.1 (1996), WHA54.12 (2001), WHA59.27 (2006) and WHA64.7 (2011).

Reaffirming Member States' commitment to strengthen nursing and midwifery by investing in education, jobs, leadership and service delivery, including the role of nurses and midwives in the health, social and educational systems,

1. ADOPTS the global strategic directions for nursing and midwifery 2021–2025;¹

2. CALLS ON Member States:^{2,3}

(1) to the extent possible, to implement the policy priorities of the global strategic directions for nursing and midwifery 2021–2025 related to education, jobs, leadership and service delivery as relevant to national health and socioeconomic development strategies, aiming to achieve the four strategic directions and the enabling monitoring mechanisms;

(2) to invest in, inter alia, workplace policies, strategic planning, capacity-building, domestic resource mobilization, additional budgetary allocation as applicable, with a view to ensuring the enhanced status of and the protection and welfare of nurses and midwives, taking into account possible and future emergencies, disasters and conflicts;

(3) to maximize the contributions of nurses and midwives in service delivery environments by seeking to ensure that practice regulations are up to date in order that nurses and midwives may practice at the pinnacle of their capability and that workplaces provide decent work, fair remuneration and working conditions, including appropriate leave entitlements, gender equity and balance, labour protection and rights, mental health and the prevention of violence and harassment, including sexual harassment and abuse;

(4) to ensure that nurses and midwives are supported, protected, motivated, sufficiently aided, trained and equipped to safely and effectively contribute in their practice settings and remove barriers to their practice, including impediments to gender equality, and mitigate their exposure to violence and harassment;

(5) to equip nurses and midwives with the requisite competencies, and professionalism, aiming to fully meet health system needs, through a scale-up of education tailored to current and future population health needs, including, but not limited to, collaborating with the WHO Academy;

(6) to facilitate the practice of nursing and midwifery professionals to the full extent of their education and training while also providing for sufficient oversight and mentoring and for lifelong in-service training and further skills development in the workplace;

(7) to enhance the capacity of educational institutions to deliver competency-based clinical and professional development programmes and develop research capacity, including evidence-based approaches in partnership with its teaching institutions;

(8) as applicable, to increase access to health services by sustainably creating nursing and midwifery jobs with fair remuneration, effectively recruiting and retaining nurses and midwives where they are needed most, and ethically managing international mobility and migration in

¹ Global strategic directions for nursing and midwifery 2021–2025. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/344562>, accessed 20 September 2021).

² And, where applicable, regional economic integration organizations.

³ Taking into account the context of federated States where health is a shared responsibility between national and subnational authorities.

accordance with the WHO Global Code of Practice on the International Recruitment of Health Personnel;

(9) to establish and strengthen national and subnational senior leadership roles for nurses and midwives with authority and responsibility for management of nursing and midwifery workforces and input into health decision-making, including as regulators of nursing and midwifery education and practice;

(10) to consider appointing government chief nursing and midwifery officers as per the recommendations in the global strategic directions for nursing and midwifery 2021–2025 and aligned, where appropriate, with the WHO guidance on their roles and responsibilities;¹

(11) as applicable, to strengthen institutional mechanisms for country coordination among senior nursing and midwifery leaders and their counterparts in academia, professional associations and regulatory bodies; and foster future generations of nursing and midwifery leaders through supported leadership skills development programmes;

(12) to facilitate the monitoring of implementation of the global strategic directions for nursing and midwifery 2021–2025 via, inter alia, the annual reporting through national health workforce accounts (resolution WHA69.19 (2016)) and the biennial WHO Global Forum for Government Chief Nursing and Midwifery Officers;

(13) to provide, to the extent possible, technical and financial assistance to developing countries, especially least developed countries and the small island developing States and humanitarian settings, aimed at strengthening health systems health personnel development, including specialized training on nursing and midwifery and investments in information systems, to assist with addressing workforce shortages and/or capacity-related challenges;

(14) as applicable, to align official development assistance for nursing and midwifery education and employment with national health workforce and health sector development strategies;

(15) to provide, to the extent possible, appropriate financial and technical support related to nursing and midwifery workforce capacities to developing countries with special circumstances, including fragile health systems that are also battling the COVID-19 pandemic;

(16) to aim to complete the commemorative activities under the International Year of the Nurse and the Midwife, which would have been disrupted due to the COVID-19 pandemic and cooperate with national nurses and midwives associations to plan and execute commemorative activities to end the International Year of the Nurse and the Midwife in 2021;

(17) to continue to implement the WHO Global Code of Practice on the International Recruitment of Health Personnel and the latest recommendations of the WHO Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel to equitably strengthen health systems worldwide, to mitigate the negative effects of health personnel migration on the health systems of countries and to report to the WHO Secretariat on the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel, including data on international health

¹ Roles and responsibilities of government chief nursing and midwifery officers: a capacity-building manual. Geneva: World Health Organization; 2015 (https://www.who.int/hrh/nursing_midwifery/15178_gcnmo.pdf, accessed 20 September 2021).

workforce migration, data from health personnel information systems, and measures taken, results achieved and difficulties encountered in implementation;

(18) to encourage and facilitate, as appropriate, the establishment and strengthening of professional councils for nursing and midwifery as relevant to context;

(19) to take part in the Gender Equal Health and Care Workforce Initiative;

3. CALLS ON international, regional, national and local partners and stakeholders from within the health sector and beyond to engage in and support implementation of the global strategic directions for nursing and midwifery 2021–2025, specifically calling for:

(1) to the extent possible, educational and other institutions within and outside the health systems to adapt their programmes and instructional modalities aiming at providing competency-based education and learning inclusive of appropriate technology, interprofessional learning and culturally competent care; to work in synergy with accrediting bodies to address capacity gaps and faculty development needs; and to collect and share institutional data essential for national health labour market analyses and informed health workforce planning;

(2) professional councils and regulatory bodies to update and strengthen professional nursing and midwifery policies, regulations and standards, as applicable, and enhance regulatory capacity, including through the collaboration of authorities responsible for health, education and employment, where indicated; modernize registries and information systems, as applicable, to enable the sharing of updated and accurate data on nurses and midwives and facilitate safe and efficient mobility across jurisdictions;

(3) private recruitment agencies and other relevant actors to employ ethical recruitment practices, as well as assist in addressing maltreatment of migrant health workers in the recruitment process and strengthening the relevance, effectiveness and implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel;

(4) professional associations and trade unions to mobilize collective action and advocacy for investments in nursing and midwifery education, jobs, leadership and service delivery; to engage in data, dialogue and decision-making forums; and advance the ILO's Decent Work Agenda for safe and equitable workplaces;

(5) donors and development partners, along with international financing institutions, regional development banks, and other public and private financing and lending institutions, to prioritize sustainable and scalable investments in education, jobs, leadership and quality service delivery in the health and care sectors, including the nursing and midwifery workforce;

(6) private sector entities to support investments in competency-based education, scholarships and training, and upgrading qualifications, in order to meet changing health system demands and population health needs;

(7) partners to continue to support initiatives and campaigns such as the Nursing Now Challenge and the Young Midwifery Leaders Programme, which raise the status and profile of nursing and midwifery in order to, inter alia, achieve greater investment in improving education, professional development and employment conditions, as well as to enhance the influence of nurses and midwives on global and national health policy, as supported by the International Year of the Nurse and the Midwife;

(8) all partners to support WHO's efforts on the International Year of Health and Care Workers for 2021, and to join its campaign to: #Protect, #Invest, #Together;

(9) partners to take part in the Gender Equal Health and Care Workforce Initiative;

4. REQUESTS the Director-General:

(1) to provide support to Member States, upon request, to optimize the contributions of nursing and midwifery towards national health policies and the Sustainable Development Goals, including implementing and monitoring the global strategic directions for nursing and midwifery 2021–2025;

(2) to strengthen the progressive development and implementation of national health workforce accounts to improve the availability, quality and completeness of health workforce data as the basis for evidence-informed policy dialogue and decision-making;

(3) to mainstream in WHO, new support initiatives implemented as a result of the COVID-19 pandemic, and which have had a positive impact on nursing and midwifery services and health care services delivery generally in Member States;

(4) to develop technical guidelines and global policy recommendations related to nursing and midwifery, including on rural retention and managing migration, taking into account lessons learned and experience sharing from the COVID-19 pandemic;

(5) to scale up assistance to developing countries especially least developed countries and small island developing States, and in humanitarian settings that face particular difficulties in educating, and developing the nursing and midwifery sector, and retaining nurses and midwives, through, inter alia, advocacy, evidence-based studies and data reporting;

(6) to engage Member States and all relevant stakeholders to develop, in consultation with Member States, a succinct compilation document under the name of "global health and care worker compact", following up on resolution WHA73.1 (2020) and decision WHA73(30) (2020), based on already existing documents of relevant international organizations (in any case WHO and ILO), which aims at providing Member States, stakeholders and other relevant organizations with technical guidance on how to protect health and care workers, safeguard their rights, and to promote and ensure decent work, safe and enabling practice environments free from racial and all other forms of discrimination, particularly in respect of the equity and gender-based challenges faced by the global nursing and midwifery workforce, in line with the WHO Global Code of Practice on the International Recruitment of Health Personnel;

(7) to support Member States, and senior government nursing and midwifery leaders in particular, to leverage the national nursing and midwifery workforce data for intersectoral policy dialogue and evidence-based decision-making on how to strengthen nursing and midwifery towards population health goals, including participating in the biennial WHO Global Forum for Government Chief Nursing and Midwifery Officers;

(8) with their prior consent, to publish the list of government chief nursing and midwifery officers on the WHO website and take responsibility for its regular updating;

(9) to strengthen the relevance, effectiveness and implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel, including by continuously fostering bilateral and multilateral dialogue and cooperation to promote mutuality of benefits

deriving from the international mobility of health workers, as well as strengthening engagement with non-State actors, including recruiters;

(10) to encourage and support all Member States to report on the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel, and urge Member States' accountability, in accordance with national context and priorities, to their reporting commitments;

(11) to report regularly to the Health Assembly on the progress made in implementing this resolution, integrated with reporting on the Global Strategy on Human Resources for Health: Workforce 2030 and aligned with reporting requirements of the WHO Global Code of Practice on the International Recruitment of Health Personnel in 2022 and 2025.

(Seventh plenary meeting, 31 May 2021 –
Committee B, third report)

WHA74.16 Social determinants of health¹

The Seventy-fourth World Health Assembly,

Having considered the consolidated report by the Director-General;²

Recalling the Constitution of the World Health Organization, which recognizes that health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, and that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Recalling also resolution WHA62.14 (2009) on reducing health inequities through action on the social determinants of health, and resolution WHA65.8 (2012) on the outcome of the World Conference on Social Determinants of Health;

Recalling further United Nations General Assembly resolution 70/1 (2015), entitled “Transforming our world: the 2030 Agenda for Sustainable Development”, and its Sustainable Development Goals;

Also recalling United Nations General Assembly resolution 74/2 (2019), entitled “Political declaration of the high-level meeting on universal health coverage”, which acknowledges the need to tackle health inequities and inequalities within and among countries through political commitment, policies and international cooperation, including those that address social, economic and environmental and other determinants of health;

Further recalling the report of the WHO Commission on Social Determinants of Health;³

¹ See Annex 4 for the financial and administrative implications for the Secretariat of this resolution.

² Document A74/9.

³ Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. Geneva: World Health Organization; 2008 (<https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1>, accessed 1 July 2021).

Recalling also the Rio Political Declaration on Social Determinants of Health (2011) and acknowledging its tenth anniversary in 2021;

Reiterating the collective determination to reduce health inequities by taking action on social determinants of health, as called for by the Health Assembly;

Recognizing the need to do more at all levels to accelerate progress in addressing the unequal and inequitable distribution of health, as well as conditions damaging to health;

Recognizing also that achieving health equity requires the engagement and collaboration of all sectors of government, all segments of society and all members of the international community, in all-for-equity and health-for-all global actions;

Recognizing further the benefits of achieving universal health coverage, including financial risk protection, access to quality health care services and access to safe, effective, quality and affordable medicines and vaccines, in enhancing health equity and reducing impoverishment;

Reaffirming the political will to make health equity a national, regional and global goal and to address current challenges, such as: eradicating hunger and poverty; ensuring food security and improved nutrition; ensuring inclusive and equitable quality education; addressing gender-, age- and disability-related inequalities in health; ensuring access to health promotion, preventive and community health services; ensuring access to safe, effective, quality and affordable medicines and vaccines; ensuring access to safe and affordable drinking water, and adequate and equitable sanitation and hygiene; fostering employment, decent work and social protection; protecting the environment and addressing ambient and household air pollution; ensuring access to safe and affordable housing; and promoting sustained, inclusive and sustainable economic growth through resolute action on social determinants of health across all sectors and at all levels;

Stressing that stigma and negative stereotyping and attitudes can affect health, including by creating and enhancing health disparities between persons;

Appreciating the tremendous health gains achieved over the past century, but expressing concern that, despite the achievements towards universal health coverage, their distribution has been vastly unequal, and that inequities in many health outcomes exist both within and between countries;

Recognizing that the ongoing coronavirus disease (COVID-19) pandemic has highlighted and even intensified pre-existing social, gender and health inequities within and among countries, and has also highlighted the need to strengthen the efforts to address social determinants of health as an integral part of the national, regional and international response to the health and socioeconomic crises generated by the current pandemic and to future public health emergencies;

Concerned that the impact of the COVID-19 pandemic has disproportionately affected those in vulnerable situations and those already in poor health, and has exacerbated their vulnerability and exposure to socioeconomic drivers, leading to increases in morbidity and mortality, as well as economic damage at the individual and community levels;

Recognizing the consequences for health of the adverse impact of climate change, natural disasters and extreme weather events as well as other environmental determinants of health, such as clean air, safe drinking water, sanitation, safe, sufficient and nutritious food, and secure shelter; and, in this regard, underscoring the need to foster health in climate change adaptation efforts, underlining that resilient and people-centred health systems are necessary to protect the health of all people, in particular those who are vulnerable or in vulnerable situations, particularly those living in small island developing States;

Recognizing also the need to establish, strengthen and maintain existing monitoring systems, including platforms and mechanisms, such as observatories,¹ that provide disaggregated data, to assess inequities in health, their relation to social determinants of health and the impacts of policies on the social determinants of health at the national, regional and global levels,

1. CALLS ON Member States² to strengthen their efforts on addressing the social, economic and environmental determinants of health with the aim of reducing health inequities, and to accelerate progress in addressing the unequal distribution of health resources within and among countries, as well as conditions detrimental to health at all levels and in support of the 2030 Agenda for Sustainable Development;
2. FURTHER CALLS ON Member States² to monitor and analyse inequities in health using cross-sectoral data in order to inform national policies that address social determinants of health, to which end Member States may establish monitoring systems of social determinants of health, including platforms and mechanisms, such as observatories, or rely on or strengthen, as appropriate, existing structures, such as national public health institutes or national statistical offices;
3. ENCOURAGES Member States² to integrate considerations related to social determinants of health into public policies and programmes, by applying a Health in All Policies approach, and in order to improve population health and reduce health inequities;
4. INVITES Member States,² international organizations and other relevant stakeholders, including intergovernmental and nongovernmental organizations, academic institutions, scientific researchers and the private sector, to mobilize financial, human and technological resources to enable the monitoring and addressing of social determinants of health;
5. CALLS ON Member States² to consider social, economic and environmental determinants of health in their recovery from the ongoing COVID-19 pandemic and in boosting resilience to both the current pandemic and future public health emergencies;
6. REQUESTS the Director-General:
 - (1) to support Member States, upon request, in the establishment or strengthening of monitoring systems of social determinants of health and health inequities, including, as appropriate, platforms and mechanisms, such as observatories;
 - (2) to prepare, building on the report of the WHO Commission on Social Determinants of Health (2008) and subsequent work, an updated report based on scientific evidence, knowledge and best practices on social determinants of health, their impact on health and health equity, progress made in addressing them, and recommendations on future actions, and to submit it for consideration by the Seventy-sixth World Health Assembly in 2023, through the Executive Board at its 152nd session;
 - (3) to prepare, in consultation with Member States and other relevant stakeholders, an operational framework, building on the work of the WHO Commission on Social Determinants of Health, and building on existing resources and tools and subsequent work, for measuring, assessing and addressing, from a cross-sectorial perspective, the social determinants of health and health inequities, as well as their impact on health outcomes, and to submit it for consideration

¹ Platforms and mechanisms for gathering, harmonizing, analysing and disseminating data and information.

² And, where applicable, regional economic integration organizations.

by the Seventy-sixth World Health Assembly in 2023, through the Executive Board at its 152nd session;

(4) to provide Member States, upon their request, with technical knowledge, and support, including for capacity-building in the design and implementation of cross-sectoral strategies, policies and plans to address inequities in health and the social, economic and environmental determinants of health;

(5) to foster and facilitate knowledge exchange among Member States and relevant stakeholders on best practices for intersectoral action on the social, economic and environmental determinants of health in order to achieve health equity and gender equality for all;

(6) to continue to strengthen collaboration with other entities of the United Nations system and other multilateral organizations, civil society and the private sector to address, from a cross-sectoral perspective, as appropriate, the social determinants of health in support of the 2030 Agenda for Sustainable Development, including through universal health coverage and in the response to the COVID-19 pandemic, including its recovery phase;

(7) to work collaboratively with academic institutions and scientific researchers to generate and make available scientific evidence and best practices on cross-sectoral interventions addressing the social, economic and environmental determinants of health and their impact on health inequities and health outcomes, as well as on the well-being of the population;

(8) to report on the implementation of this resolution to the Seventy-sixth World Health Assembly in 2023, through the Executive Board at its 152nd session.

(Seventh plenary meeting, 31 May 2021 –
Committee B, fourth report)

WHA74.17 Ending violence against children through health systems strengthening and multisectoral approaches¹

The Seventy-fourth World Health Assembly,

Having considered the report² on the WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children;³

Recalling that all children have the right to the enjoyment of the highest attainable standard of physical and mental health;

Also recalling that all children should be free from violence, and resolution WHA49.25 (1996) on prevention of violence, which declared violence a leading worldwide public health problem, resolution WHA56.24 (2003) on implementing the recommendations of the *World report on violence and health*, resolution WHA61.16 (2008) on female genital mutilation, and resolution WHA67.15

¹ See Annex 4 for the financial and administrative implications for the Secretariat of this resolution.

² Document A74/21.

³ Children are classed as all persons under 18 years of age.

(2014) on strengthening the role of the health system in addressing violence, in particular against women and girls, and against children;

Cognizant of efforts across the United Nations system to address the challenge of violence against children including through the Convention on the Rights of the Child, as applicable, its optional protocols and its committee, the United Nations Special Representative of the Secretary-General on Violence against Children, the 2030 Agenda for Sustainable Development and specifically target 16.2 of the Sustainable Development Goals (End abuse, exploitation, trafficking and all forms of violence against and torture of children) and other relevant targets of the Goals, and mindful of the importance of multisectoral engagement and collaboration in preventing and responding to violence against children;

Noting that violence is defined by WHO as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation”;¹

Recalling resolution WHA67.15 (2014) on strengthening the role of the health system in addressing violence, in particular against women and girls, and against children, which noted that interpersonal violence, distinguished from self-inflicted violence and collective violence, is divided into family and partner violence and community violence, and includes forms of violence throughout the life course, such as child abuse, partner violence, abuse of elderly people, violence between family members, youth violence, random acts of violence, rape or sexual assault, and violence in institutional settings such as schools, workplaces, prisons and nursing homes;

Also noting that violence against children involves all forms of violence against people under 18 years old, and includes, but is not limited to, child maltreatment involving physical, sexual and psychological violence, and neglect of children by parents, caregivers and other authority figures, bullying (including cyberbullying) at the hands of other children, sexual violence including rape, sexual trafficking, online exploitation and non-contact violence such as sexual harassment, and psychological violence such as denigration, threats and intimidation, and other non-physical forms of hostile treatment;^{1,2} and further noting concern over harmful practices, such as child, early and forced marriage and female genital mutilation;

Deeply concerned that each year violence affects an estimated one billion children, with many early, acute and lifelong, intergenerational consequences on physical and mental health, risk-taking behaviours and overall quality of life, including mental health conditions, physical injuries, impairments and death;

Recognizing that violence against women and girls, and against children, is a violation of human rights that further exacerbates gender inequalities by exposing individuals to heightened risk of violent behaviour and an increased risk of being subjected to violence at a later stage in life, and that ending violence against children is essential to the long-term prevention of violence;

Also recognizing that exposure to a mother’s abuse by a partner has similar mental and physical health impacts on children to maltreatment, and that violence against children and against women can occur in the same households, and that it is therefore critical to address the intersections of these two

¹ Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. World report on violence and health. Geneva: World Health Organization; 2002.

² Violence against children [factsheet]. Geneva: World Health Organization; 2020 (<https://www.who.int/news-room/fact-sheets/detail/violence-against-children>, accessed 7 July 2021).

forms of violence and eliminate common risk factors, as a prerequisite to long-term prevention of violence against women and violence against children;

Further recognizing that over the course of their lifetime, children exposed to all forms of violence are at increased risk of delayed cognitive development, mental health conditions, high-risk and health-harming behaviours, and further interpersonal and self-directed violence, and that as a result of these they are more likely to be affected by noncommunicable diseases, sexually transmitted diseases, reproductive health problems and other negative social consequences including educational under-attainment;

Noting that violence against children costs the world economy between US\$ 1.49 trillion and US\$ 6.9 trillion annually, that many of the economic costs fall to the health sector as it provides treatment for the acute and long-term consequences, and that this likely represents an underestimation of the full costs of violence against children since it does not consider the long-term impacts on future human capital formation of children exposed to violence;

Also noting with concern that the growing economic and financial burden aggravated by coronavirus disease (COVID-19) will further exacerbate inequalities, increase poverty and hunger, and reverse the hard-won developmental gains, including in the health sector;

Further noting that the COVID-19 pandemic has triggered significant new needs and magnified pre-existing inequalities and vulnerabilities, leading to an increased risk of violence involving children and women, and increases in harmful practices and crimes resulting from, inter alia, closures of schools and protective services, increased isolation, emotional and economic burden on households, and mental health conditions, which threaten multiple aspects of children's physical, psychological, sexual and reproductive health;

Recognizing that state institutions can also be sites of violence, including violence in schools perpetrated by teachers and peers, noting that children face various forms of online violence as well as violence facilitated by information and communications technology (ICT), and that online and ICT-facilitated violence is disproportionately affecting women and girls;

Concerned about the occurrence of bullying, both online and offline, in all parts of the world and the fact that children who are victimized by such practices may be at heightened risk of compromising their health, emotional well-being and academic work and a wide range of physical and/or mental health conditions, as well as about the potential long-term effects on the individual's ability to realize her or his own potential;

Also recognizing that violence against girls is based on discrimination, gender norms and gender inequalities and includes sexual and gender-based violence, child maltreatment, child, early and forced marriage, sexual harassment, female genital mutilation, partner violence, trafficking, and sexual exploitation and abuse, all of which requires specific attention by society, including health providers;

Further recognizing that close interlinkages exist between the different forms of discrimination, violence and inequalities faced by children;

Stressing that discrimination based on gender or age often overlaps with other forms of discrimination, as well as a range of social determinants, and that this may affect a child's vulnerability to violence and often compounds the impacts of crisis and conflict on children;

Recognizing also that children with disabilities are more likely than other children to experience physical, psychological, sexual and gender-based violence and neglect;

Recognizing further the special needs of and risks faced by migrant children, especially unaccompanied migrant children or children separated from their families, particularly with regard to all forms of violence, discrimination and exploitation, including sexual and gender-based violence, physical and psychological abuse, human trafficking and contemporary forms of slavery;

Noting that victims of all forms of violence frequently suffer traumatic consequences that require care and treatment, and that psychosocial support needs to be provided to both victims and perpetrators to mitigate risks of violence in the future;

Recognizing also that health systems are often not adequately addressing the problem of violence and the risk factors and determinants that cut across all forms of interpersonal violence, including violence against children, and not always contributing to a comprehensive, coordinated and multisectoral prevention and response to violence against children, and that strengthening health systems and achieving universal health coverage are essential to addressing both the risk factors for and determinants of violence against children and its consequences;

Recognizing further that violence against children needs continuous, coordinated and multisectoral action for prevention, detection, response and monitoring;

Concerned that violence against children is often exacerbated in humanitarian emergencies and in countries in conflict and post-conflict situations, and recognizing that health systems have an important role to play in preventing and responding to its consequences, underlining the need to protect health care facilities from attacks to ensure the delivery of health care services;

Also recognizing that ensuring safe access and safeguarding the right to education, including in humanitarian emergencies and in countries in conflict and post-conflict situations, provides an environment that protects against violence and is an entry point for basic health and nutrition interventions;

Acknowledging the need for greater international cooperation and technical assistance at all levels to address the issue of violence against children including in humanitarian emergencies and in countries in conflict and post-conflict situations;

Stressing the importance of scaling up evidence-based preventive measures in line with obligations under the Convention on the Rights of the Child, including appropriate legislative, administrative, social and educational measures, to protect children from all forms of violence, including parent and caregiver support programmes and school- and community-based interventions, and public health and other measures to positively promote respectful child-rearing, free from violence, for all children, and to target the root cause of violence at the levels of the child, family, perpetrator, community, institution and society, and noting that these measures can be delivered by and with the health and other relevant sectors and civil society organizations,

1. URGES Member States:¹

- (1) to establish an interministerial coordination process to prevent and eliminate violence against children following an evidence-based approach based on respect for human rights to coordinate a gender-sensitive strategy to address violence against children with clear support from the highest levels of government;

¹ And, where applicable, regional economic integration organizations.

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- (2) to include children, as appropriate to their evolving capacities, in advocacy, policy development and action, taking into account their experiences and needs, in the prevention and elimination of violence against children and to provide accessible and age-appropriate information to children;
 - (3) to promote an intercultural perspective while addressing violence against children in order to adapt effective interventions and meet the needs of children in different contexts, and to strengthen the capacities of community health workers, communities and families to prevent situations of risk;
 - (4) to strengthen health system leadership and governance to prevent violence against children, including by creating or designating where appropriate, a unit or focal point within health ministries to address issues related to violence against children, and liaising with other competent national ministries, departments and agencies, and, where applicable, with national child protection institutions, taking into consideration a Health in All Policies approach to prevent and respond to violence against children;
 - (5) to take stock of their legislative policy and response frameworks for prevention of violence against children as well as implementation channels, and to strengthen these where necessary including by ensuring they are gender- and age-sensitive and prioritizing improved disaggregated data collection as well as monitoring and using relevant data to set prevention and response measures and targets;
 - (6) to allocate the necessary budget for the prevention of and response to violence against children in relevant national plans and policies;
 - (7) to enhance international cooperation for the provision of requisite resources and bridging the financial gaps for the implementation of strategies and policies to prevent and counter violence against children and to promote their well-being by responding to the consequences of violence;
 - (8) to strengthen their efforts to support the implementation of evidence-based approaches consistent with the INSPIRE framework for ending violence against children¹ to accelerate progress in achieving target 17 of WHO's Thirteenth General Programme of Work 2019–2023 (to decrease the number of children subjected to violence in the past 12 months, including physical and psychological violence by care givers in the past month, by 20%), taking into account the WHO-developed RESPECT women framework, in accordance with the national context;
 - (9) to increase the capacity of health systems to identify violence against children, inter alia, by strengthening health information systems to capture age- and sex-disaggregated data on violence against children, and equipping health and other relevant service providers with the skills to recognize the risks of violence against children and the signs, symptoms and consequences of child maltreatment and all other forms of violence against children, with particular attention to the needs of children with disabilities, children in vulnerable situations such as migrant children, and children in areas of armed conflict, and to provide evidence-based, trauma-informed first-line support, reporting and referral, with the best interests of the child as a primary consideration and free of abuse, disrespect and discrimination;
 - (10) to establish policies and monitoring mechanisms on safeguarding children and child protection for all governmental and nongovernmental staff who come into contact with children, as well as to support coordinated efforts across all sectors to train and equip, among others,

¹ INSPIRE: seven strategies for ending violence against children. Geneva: World Health Organization; 2016.

teachers, school administrators, religious leaders, parents and their representative organizations, justice and social welfare sector actors, detention officers, prison staff, health practitioners and sports workers and community and faith-based groups with the skills to prevent, identify and respond to violence against children, especially adolescent girls, who, owing to negative social norms, are more likely to be subject to gender-based violence, and face a greater risk of harmful practices, such as child, early and forced marriage, and female genital mutilation, and other factors of great importance such as trafficking in persons, child labour and unintended pregnancies, which may also lead to girls leaving school before the completion of their education and never returning to school;

(11) to ensure that child protection, including social protection and mental health services, is recognized as essential and that it continues to be provided and be accessible and available to all children at all times, including during lockdowns, quarantines and other types of confinement and public health measures;

(12) to strengthen implementation of WHO's global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children, in accordance with national legislation, capacities and priorities, and specific national circumstances, to ensure that all people at risk and/or affected by violence benefit from prevention and timely, safe, effective and affordable access to health care services;

(13) to respect, protect, promote and fulfil the human rights of all women and girls, and to adopt and expedite the implementation of laws, policies and programmes that protect and enable the enjoyment by them of all human rights and fundamental freedoms, including with regard to sexual and reproductive health;

(14) to develop strategies, or include in existing strategies, measures for the prevention and elimination of all forms of violence against children with disabilities, who are particularly vulnerable to, inter alia, cruel, inhuman, degrading treatment, medical or scientific experimentation, and sexual and physical violence, including bullying and cyberbullying, and to develop and introduce child- and gender-sensitive, accessible, safe and confidential reporting and complaints mechanisms;

(15) to develop and/or improve epidemiological surveillance systems capable of ongoing and timely identification and description of epidemiological behaviour, monitoring trends, identifying risk factors and recommending and adopting measures for the prevention of and response to violence, as well as for assessing the impact of multisectoral measures and interventions;

2. REQUESTS the Director-General:

(1) to prepare a second and third global status report on preventing violence against children to assess national violence prevention status in 2025 and 2030, respectively, and to support nationally representative surveys on the extent of all forms of violence against children and its consequences in all settings;

(2) to provide Member States and humanitarian actors with technical knowledge and support, including to collect data and to train health, care and other relevant service providers in identifying and responding to violence against children, and capacity-building in the design and implementation of evidence-based strategies to prevent and respond to violence against children consistent with the INSPIRE framework and the national context, noting also the need to address violence against children, including gender-based violence, among persons and populations in humanitarian emergencies and in countries in conflict and post-conflict situations;

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- (3) to provide support to Member States in developing and implementing evidence-based parenting programmes to prevent child maltreatment and promote healthy child development, and contribute to reducing inequalities in health consistent with the INSPIRE framework and the national context, and as requested, to also provide support to Member States in the involvement of children, as appropriate to their evolving capacities, in developing implementation plans, taking into account their experiences and needs, and in following up on these programmes;
- (4) to foster and facilitate knowledge exchange among academic institutions, scientific researchers, practitioners, individuals with lived experiences, and children, as appropriate to their evolving capacities, at the country, regional and global levels on best practices to prevent violence against children;
- (5) to further strengthen collaboration with other mandated United Nations entities and multilateral organizations and civil society to prevent and address violence against children, including sexual- and gender-based violence through a multisectoral approach, and support implementation of relevant strategies, consistent with the INSPIRE framework and the national context, in support of the 2030 Agenda for Sustainable Development and in the response to the COVID-19 pandemic and its recovery phase;
- (6) to strengthen the capacity of WHO's regional and country offices to prevent violence;
- (7) to report on the implementation of this resolution to the Seventy-sixth World Health Assembly in 2023, through the Executive Board at its 152nd session, and thereafter as part of the reporting on resolution WHA69.5 (2016) on the WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children, in 2025 and 2030, respectively.

(Seventh plenary meeting, 31 May 2021 –
Committee B, fourth report)

DECISIONS

WHA74(1) **Composition of the Committee on Credentials**

The Seventy-fourth World Health Assembly appointed a Committee on Credentials consisting of delegates of the following 12 Member States: Andorra, Australia, Cameroon, Haiti, Iceland, Mali, Monaco, Namibia, Panama, Singapore, Somalia, Thailand.

(First plenary meeting, 24 May 2021)

WHA74(2) **Election of officers of the Seventy-fourth World Health Assembly**

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

President:	Ms Dechen Wangmo (Bhutan)
Vice-Presidents:	Professor Benjamin Hounkpatin (Benin) Mr Enkhbold Sereejav (Mongolia) Dr Hanan M. Al-Kuwari (Qatar) Mr Tanel Kiik (Estonia) Dr Amelia Flores (Guatemala)

(First plenary meeting, 24 May 2021)

WHA74(3) **Election of officers of the main committees**

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

Committee A:	Chair	Dr Adriana Amarilla (Paraguay)
Committee B:	Chair	Dr Ifereimi Waqainabete (Fiji)

(First plenary meeting, 24 May 2021)

The main committees subsequently elected the following officers:

Committee A:	Vice-Chair	Dr Zwelini Mkhize (South Africa) Dr Ali Muhammad Miftah Al-Zinati (Libya)
	Rapporteur	Professor Plamen Dimitrov (Bulgaria)
Committee B:	Vice-Chair	Dr Søren Brostrøm (Denmark) Ms Kazi Zebunnessa Begum (Bangladesh) Mr Mustafir Rahman (Bangladesh) <i>ad interim</i>
	Rapporteur	Lt. Col. Jeffrey Bostic (Barbados)

(First meetings of Committees A and B,
24 and 26 May 2021, respectively)

WHA74(4) Establishment of the General Committee

The Seventy-fourth World Health Assembly, elected the delegates of the following 17 countries as members of the General Committee: Algeria, Burundi, Canada, Chile, China, Cuba, Djibouti, France, Oman, Philippines, Portugal, Russian Federation, Sri Lanka, United Kingdom of Great Britain and Northern Ireland, United States of America, Zambia, Zimbabwe.

(First plenary meeting, 24 May 2021)

WHA74(5) Special procedures

The Seventy-fourth World Health Assembly having considered the report on special procedures,¹

Decided to adopt the special procedures set out in the Annex to this decision in order to regulate the conduct of virtual meetings of the Seventy-fourth World Health Assembly opening on 24 May 2021 and closing no later than 1 June 2021.

ANNEX**SPECIAL PROCEDURES TO REGULATE THE CONDUCT OF VIRTUAL MEETINGS OF THE WORLD HEALTH ASSEMBLY****RULES OF PROCEDURE**

1. The Rules of Procedure of the Health Assembly shall continue to apply in full, except to the extent that they are inconsistent with these special procedures, in which case the Health Assembly's decision to adopt these special procedures shall operate as a decision to suspend the relevant Rules of Procedure to the extent necessary in accordance with Rule 122 of the Rules of Procedure of the Health Assembly.²

ATTENDANCE

2. Attendance by Member States, Associate Members, Observers, invited representatives of the United Nations and of other participating intergovernmental organizations, as well as non-State actors shall be through a secured access to videoconference or other electronic means allowing representatives to hear other participants and to address the meeting remotely.

QUORUM

3. It is understood that virtual attendance of Member States shall be taken into account when calculating the presence of a quorum.

¹ Document A74/45.

² This will affect notably the relevant provisions of the following Rules of Procedure of the World Health Assembly as they appear in the 49th edition of *Basic documents*:

- Rules 73, 78–79 and 81–86 (voting by show of hands and secret ballot); and
- Rule 121 (amendments and additions to the Rules of Procedure) insofar as these special procedures may be regarded as additions to the Rules of Procedure and to the extent that Rule 121 requires receipt and consideration of a report thereon by an appropriate committee.

ADDRESSING THE HEALTH ASSEMBLY

4. Member States, Associate Members, Observers, invited representatives of the United Nations and of other participating intergovernmental organizations as well as, at the invitation of the presiding officer, non-State actors in official relations with the Organization, shall be provided with the opportunity to take the floor.

5. Member States and Associate Members shall also have the opportunity, if they so wish, to submit individual pre-recorded video statements of no more than three minutes, and regional and group statements of no more than four minutes. Pre-recorded video statements should be submitted in advance of the opening of the session. The video statements so submitted shall be broadcast in lieu of a live intervention.

6. Any Member State wishing to raise a point of order or exercise a right of reply in relation to either an oral or a pre-recorded video statement made at the Health Assembly should signal their intention to do so. It is understood that, in accordance with well-established practice, any right of reply to either an oral or a pre-recorded video statement shall be exercised at the end of the relevant meeting.

DECISION-MAKING

7. All decisions of the Health Assembly should as far as possible be taken by consensus. In any event, no decision shall be taken by show of hands or secret ballot.

8. In the event that a vote is required, voting shall take place by roll call conducted through the virtual system.

9. During a roll-call vote, should any delegate fail to cast a vote for any reason during the roll call, that delegate shall be called upon a second time after the conclusion of the initial roll call. Should the delegate fail to cast a vote on the second call, the delegation concerned shall be recorded as absent.

10. The procedures set out above are adopted for the purpose of the Seventy-fourth World Health Assembly only as exceptional measures to enable the work of the Organization to continue during the extraordinary situation arising from the COVID-19 pandemic and they should not be considered as setting a precedent for future Health Assemblies.

(First plenary meeting, 24 May 2021)

WHA74(6) Adoption of the agenda

The Seventy-fourth World Health Assembly adopted the provisional agenda prepared by the Executive Board at its 148th session, with the deletion of three items and the exclusion of one supplementary item.

(Second plenary meeting, 24 May 2021)

WHA74(7) Verification of credentials

The Seventy-fourth World Health Assembly, accepted the credentials presented by the following 188 Member States as being in conformity with the Rules of Procedure of the World Health Assembly: Afghanistan; Albania; Algeria; Andorra; Angola; Antigua and Barbuda; Argentina; Armenia; Australia; Austria; Azerbaijan; Bahamas; Bahrain; Bangladesh; Barbados; Belarus; Belgium; Belize; Benin; Bhutan; Bolivia (Plurinational State of); Bosnia and Herzegovina; Botswana; Brazil; Brunei

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

(Fifth plenary meeting, 26 May 2021)

WHA74(8) Election of Members entitled to designate a person to serve on the Executive Board

The Seventy-fourth World Health Assembly, after considering the recommendations of the General Committee, elected the delegates of the following as Members entitled to designate a person to serve on the Executive Board: Afghanistan, Belarus, Denmark, France, Japan, Malaysia, Paraguay, Peru, Rwanda, Slovenia, Syrian Arab Republic, Timor-Leste.

(Sixth plenary meeting, 28 May 2021)

WHA74(9) Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan¹

The Seventy-fourth World Health Assembly, taking note of the report by the Director-General requested in decision WHA73(32) (2020),²

Decided to request the Director-General:

- (1) to report on progress in the implementation of the recommendations contained in the report by the Director-General, based on field monitoring, to the Seventy-fifth World Health Assembly;
- (2) to support the Palestinian health sector using a health system strengthening approach, including through capacity-building programmes, improving basic infrastructure, human and technical resources and the provision of health facilities, ensuring the accessibility, affordability

¹ See Annex 4 for the financial and administrative implications for the Secretariat of this decision.

² Document A74/22.

and quality of health-care services required to address and deal with structural problems emanating from the prolonged occupation, and developing strategic plans for investments in specific treatment and diagnostic capacities locally;

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

(4) to ensure non-discriminatory, affordable and equitable access to COVID-19 vaccines to the protected occupied population in the occupied Palestinian territory including East Jerusalem and in the occupied Syrian Golan in compliance with international law;

(5) to ensure the respect and protection of wounded population and injuries, health and humanitarian aid workers, the healthcare systems, all medical and humanitarian personnel exclusively engaged in medical duties, their means of transport and equipment, as well as hospitals and other medical facilities in compliance with the Geneva Conventions and their Additional Protocols;

(6) to assess, in full cooperation with UNICEF and other relevant United Nations agencies and the WHO Regional Office for the Eastern Mediterranean and the WHO country office in the occupied Palestinian territory, including east Jerusalem, the extent and nature of psychiatric morbidity, and other forms of mental health problems, resulting from protracted aerial and other forms of bombing among the population, particularly children and adolescents, of the occupied Palestinian territory, including east Jerusalem;

(7) to continue strengthening partnership with other United Nations agencies and partners in the occupied Palestinian territory including east Jerusalem and in the occupied Syrian Golan to enhance humanitarian health response capacities by delivering aid and protection in an inclusive and sustained manner during coronavirus disease COVID-19 and after the pandemic crisis;

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

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

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

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

(Sixth plenary meeting, 28 May 2021)

WHA74(10) Follow-up of the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases¹

The Seventy-fourth World Health Assembly, having considered the consolidated report by the Director-General,²

Decided to request the Director-General to present, in response to the global action plan for the prevention and control of noncommunicable diseases 2013–2030 and the recommendations of the mid-term evaluation of the global action plan, an implementation roadmap 2023–2030 for the global action plan for the prevention and control of noncommunicable diseases 2013–2030, through the Executive Board at its 150th session, and through subsequent consultations with Member States³ and relevant stakeholders, for consideration by the Seventy-fifth World Health Assembly

(Seventh plenary meeting, 31 May 2021)

WHA74(11) The role of the global coordination mechanism on the prevention and control of noncommunicable diseases in WHO's work on multistakeholder engagement for the prevention and control of noncommunicable diseases¹

The Seventy-fourth World Health Assembly, having considered the consolidated report by the Director-General,² the mid-point evaluation of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2030,⁴ the final evaluation of the WHO global coordination mechanism on the prevention and control of noncommunicable diseases: executive summary,⁵ and the options paper on the WHO global coordination mechanism on the prevention and control of noncommunicable diseases;⁶ recalling resolution WHA66.10 (2013) on the endorsement of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020, and decision WHA72(11) (2019), which extended the global action plan until 2030; recalling also the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases (United Nations General Assembly resolution 66/2 (2011)), which recognizes, inter alia, the primary role and responsibility of governments in responding to the challenge of noncommunicable diseases by developing adequate national multisectoral responses for their prevention and control,

Decided:

(1) to extend the current terms of reference of the WHO global coordination mechanism on the prevention and control of noncommunicable diseases until 2030 with a mid-term evaluation in 2025;

(2) to request the Director-General:

¹ See Annex 4 for the financial and administrative implications for the Secretariat of this decision.

² Document A74/10 Rev.1.

³ And, where applicable, regional economic integration organizations.

⁴ Document A74/10 Add.1.

⁵ Document A74/10 Add.2.

⁶ Document A74/10 Add.3.

- (a) to ensure the continued performance of the WHO global coordination mechanism on the prevention and control of noncommunicable diseases and its functions, in line with WHO's Framework of Engagement with Non-State Actors, with a more focused approach to the delivery of its functions, and with clearly defined objectives and measurable and practical milestones that ensure that the work of the global coordination mechanism contributes to the achievement of the objectives set in the WHO global action plan on noncommunicable diseases 2013–2030, taking into consideration in a balanced manner the prevention, diagnosis and treatment of noncommunicable diseases;
- (b) to develop, in consultation with Member States and non-State actors, a workplan for the WHO global coordination mechanism on the prevention and control of noncommunicable diseases, to be submitted to the Seventy-fifth World Health Assembly, through the Executive Board at its 150th session, and to present the work undertaken and results achieved so far to Member States and non-State actors in 2022 in order to receive their further guidance on the implementation of the workplan;
- (c) to ensure that the WHO global coordination mechanism on the prevention and control of noncommunicable diseases carries out its functions in a way that is integrated with the Organization's ongoing work on noncommunicable diseases, including the following:
 - (i) as an operational backbone for knowledge collaboration and the dissemination of innovative multistakeholder responses at country level, by raising awareness and promoting knowledge collaboration among Member States and non-State actors and by co-creating, enhancing and disseminating evidence-based information to support governments on effective multisectoral and multistakeholder approaches;
 - (ii) as an enabler for the global stocktaking of multistakeholder action at country level and for co-designing and scaling up innovative approaches, solutions or initiatives to strengthen effective multisectoral and multistakeholder action;
 - (iii) by providing and updating guidance to Member States on engagement with non-State actors, including on the prevention and management of potential risks;
 - (iv) as a global facilitator for the strengthened capacity of Member States and civil society to develop national multistakeholder responses for the prevention and control of noncommunicable diseases;
 - (v) as a convener of civil society, including people living with noncommunicable diseases, to raise awareness and build capacity for their meaningful participation in national noncommunicable diseases responses;
- (d) to submit an independent evaluation to the Seventy-eighth World Health Assembly in 2025 to assess the effectiveness of the new WHO global coordination mechanism on the prevention and control of noncommunicable diseases operating model, its added value, and its continued relevance to the implementation of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020 and its implementation roadmap 2023–2030, including its possible extension.

(Seventh plenary meeting, 31 May 2021)

WHA74(12) Integrated people-centred eye care, including preventable vision impairment and blindness¹

The Seventy-fourth World Health Assembly, having considered the consolidated report by the Director-General,²

Decided to endorse the global targets for effective coverage of refractive errors and effective coverage of cataract surgery to be achieved by 2030, considered by the Executive Board at its 148th session,³ and reproduced in Annex 3.

(Seventh plenary meeting, 31 May 2021)

WHA74(13) Global action on patient safety¹

The Seventy-fourth World Health Assembly, having considered the consolidated report by the Director-General,⁴

Decided:

- (1) to adopt the global patient safety action plan 2021–2030;⁵
- (2) to request the Director-General to report back on progress in the implementation of the global patient safety action plan 2021–2030 to the Seventy-sixth World Health Assembly in 2023 and thereafter every two years until 2031.

(Seventh plenary meeting, 31 May 2021)

WHA74(14) Mental health preparedness for and response to the COVID-19 pandemic¹

The Seventy-fourth World Health Assembly, having considered the consolidated report by the Director-General,⁴

Decided to endorse the updated comprehensive mental health action plan 2013–2030, with due consideration for the plan's updated implementation options and indicators,⁶ given the need to support recovery from COVID-19, by means including promoting mental health and psychosocial well-being, building mental health services and psychosocial supports, and strengthening preparedness, response capacity and resilience for future public health emergencies.

(Seventh plenary meeting, 31 May 2021)

¹ See Annex 4 for the financial and administrative implications for the Secretariat of this decision.

² Document A74/9.

³ See document EB148/15, Annex; see also the summary records of the Executive Board at its 148th session, twelfth meeting (section 3) and fourteenth meeting (section 3).

⁴ Document A74/10 Rev.1.

⁵ Available at <https://apps.who.int/iris/handle/10665/343477> (accessed 11 October 2021).

⁶ Available at <https://apps.who.int/iris/handle/10665/345301> (accessed 11 October 2021).

WHA74(15) Implementation of the International Health Regulations (2005)¹

The Seventy-fourth World Health Assembly, having considered the report by the Director-General,²

Decided to endorse the continuation of the management of the public health emergency of international concern through temporary recommendations issued by the Director-General under the International Health Regulations (2005), on the advice of the IHR Emergency Committee for COVID-19, in connection with the public health emergency of international concern arising from the international spread of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

(Seventh plenary meeting, 31 May 2021)

WHA74(16) Special session of the World Health Assembly to consider developing a WHO convention, agreement or other international instrument on pandemic preparedness and response¹

The Seventy-fourth World Health Assembly,

Decided:

- (1) to request the Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies to prioritize the assessment of the benefits of developing a WHO convention, agreement or other international instrument on pandemic preparedness and response and to provide a report to be considered at the special session of the Health Assembly referred to in paragraph 2 of this decision;
- (2) to request the Director-General to convene a special session of the World Health Assembly in November 2021, and to include on the agenda of the special session only one item, dedicated to considering the benefits of developing a WHO convention, agreement or other international instrument on pandemic preparedness and response with a view towards the establishment of an intergovernmental process to draft and negotiate such a convention, agreement or other international instrument on pandemic preparedness and response, taking into account the report of the Working Group on Strengthening WHO Preparedness and Response to Health Emergencies referred to in paragraph 1;
- (3) to request the Executive Board at its 149th session to determine, in accordance with Rule 2 of the Rules of Procedure of the Health Assembly, that the special session of the Health Assembly referred to in paragraph 2 of this decision will be held from 29 November 2021 to 1 December 2021 at WHO headquarters, either in person or virtually, if limitations to physical meetings preclude the holding of the special session in person;
- (4) to suspend, in accordance with Rule 122 of the Rules of Procedure of the Health Assembly, and with respect to the above-referenced special session of the Health Assembly, the requirement of Rule 2 of the Rules of Procedure of the World Health Assembly, under which the Director-General is to convene a special session of the Health Assembly within 90 days of the receipt of the request therefor.

¹ See Annex 4 for the financial and administrative implications for the Secretariat of this decision.

² Document A74/17.

(Seventh plenary meeting, 31 May 2021)

WHA74(17) WHO reform: governance

The Seventy-fourth World Health Assembly, having considered the consolidated report by the Director-General,¹

Decided:

(1) to sunset reporting on the following resolutions on the understanding that the mandates have been completed or superseded by a new mandate on the same subject matter:

1. EB87.R23 (1991) – WHO fellowships;
2. WHA23.14 (1970) – Real Estate Fund;
3. WHA35.14 (1982) – Policy on patents;
4. WHA38.8 (1985) – Review of the Working Capital Fund;
5. WHA40.24 (1987) – Effects of nuclear war on health and health services;
6. WHA40.32 (1987) – Use of alcohol in medicines;
7. WHA44.5 (1991) – Eradication of dracunculiasis;
8. WHA44.27 (1991) – Health development in urban areas;
9. WHA44.36 (1991) – International programme on the health effects of the Chernobyl accident;
10. WHA47.32 (1994) – Onchocerciasis control through ivermectin distribution;
11. WHA48.9 (1995) – Prevention of hearing impairment;
12. WHA48.13 (1995) – Communicable diseases prevention and control: new, emerging, and re-emerging infectious diseases;
13. WHA49.20 (1996) – Collaboration within the United Nations system and with other intergovernmental organizations: orientation of WHO policy in support of African recovery and development;
14. WHA50.13 (1997) – Promotion of chemical safety, with special attention to persistent organic pollutants;
15. WHA50.29 (1997) – Elimination of lymphatic filariasis as a public health problem;
16. WHA51.13 (1998) – Tuberculosis;

¹ Document A74/9.

17. WHA51.15 (1998) – Elimination of leprosy as a public health problem;
 18. WHA54.19 (2001) – Schistosomiasis and soil-transmitted helminth infections;
 19. WHA55.8 (2002) – Real Estate Fund;
 20. WHA56.19 (2003) – Prevention and control of influenza pandemics and annual epidemics
 21. WHA58.27 (2005) – Improving the containment of antimicrobial resistance;
 22. WHA60.22 (2007) – Health systems: emergency-care systems;
 23. WHA63.15 (2010) – Monitoring of the achievement of the health-related Millennium Development Goals;
 24. WHA65.21 (2012) – Elimination of schistosomiasis;
 25. WHA66.24 (2013) – eHealth standardization and interoperability;
 26. WHA67.14 (2014) – Health in the post-2015 development agenda;
- (2) to sunset reporting on the following resolutions on the understanding that the subject matter will be systematically incorporated into future reports on a related subject matter:
27. WHA37.18 (1984) – Prevention and control of vitamin A deficiency and xerophthalmia;
 28. WHA42.40 (1989) – Prevention and control of salmonellosis;
 29. WHA44.42 (1991) – Women, health and development;
 30. WHA45.22 (1992) – Child health and development: health of the newborn;
 31. WHA48.12 (1995) – Control of diarrhoeal diseases and acute respiratory infections: integrated management of the sick child;
 32. WHA50.16 (1997) – Employment and participation of women in the work of WHO;
 33. WHA54.18 (2001) – Transparency in tobacco control;
 34. WHA58.22 (2005) – Cancer prevention and control;
 35. WHA58.29 (2005) – Enhancement of laboratory biosafety;
 36. WHA58.31 (2005) – Working towards universal coverage of maternal, newborn and child health interventions;
 37. WHA60.16 (2007) – Progress in the rational use of medicines;
 38. WHA60.20 (2007) – Better medicines for children;

39. WHA60.21 (2007) – Sustaining the elimination of iodine deficiency disorders;
40. WHA60.27 (2007) – Strengthening of health information systems;
41. WHA61.16 (2008) – Female genital mutilation;
42. WHA64.6 (2011) – Health workforce strengthening;
43. WHA64.7 (2011) – Strengthening nursing and midwifery;
44. WHA64.9 (2011) – Sustainable health financing structures and universal coverage;
45. WHA64.28 (2011) – Youth and health risks;
46. WHA65.20 (2012) – WHO’s response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies;
47. WHA67.4 (2014) – Supplementary funding for real estate and longer-term staff liabilities;

(3) to specify end dates for reporting on 10 resolutions with unspecified reporting requirements:¹

1. WHA63.12 (2010) – Availability, safety and quality of blood products;
2. WHA63.22 (2010) – Human organ and tissue transplantation;
3. WHA67.1 (2014) – Global strategy and targets for tuberculosis prevention, care and control after 2015;
4. WHA67.18 (2014) – Traditional medicine;
5. WHA68.2 (2015) – Global technical strategy and targets for malaria 2016–2030;
6. WHA68.19 (2015) – Outcome of the Second International Conference on Nutrition;
7. WHA69.2 (2016) – Committing to implementation of the Global Strategy for Women’s, Children’s and Adolescents’ Health;
8. WHA69.24 (2016) – Strengthening integrated, people-centred health services;
9. WHA70.6 (2017) – Human resources for health and implementation of the outcomes of the United Nations’ High-Level Commission on Health Employment and Economic Growth;
10. WHA70.13 (2017) – Prevention of deafness and hearing loss.

(Seventh plenary meeting, 31 May 2021)

¹ Proposed end dates for reporting on the 10 resolutions are indicated in document EB148/33, Annex 2.

WHA74(18) World Neglected Tropical Diseases Day

The Seventy-fourth World Health Assembly, having considered the consolidated report by the Director-General,¹

Decided to welcome the Secretariat's support of initiatives that celebrate the date of 30 January as a day dedicated to neglected tropical diseases, and invites Member States and relevant stakeholders to consider taking appropriate measures to continue celebrating that day.

(Seventh plenary meeting, 31 May 2021)

WHA74(19) Review of the entitlements of members of the Executive Board

The Seventy-fourth World Health Assembly, having considered the consolidated report by the Director-General,¹

Decided that with effect from 1 July 2021, the maximum reimbursement of travel expenses of members of the Executive Board should be based on the travel entitlements of WHO staff members.

(Seventh plenary meeting, 31 May 2021)

WHA74(20) The global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections²

The Seventy-fourth World Health Assembly, having considered the consolidated report by the Director-General,¹

Decided:

(1) to confirm the objective of the global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections to contribute to the achievement of Sustainable Development Goal target 3.3 (By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases) and other communicable disease-related goals and targets;

(2) to request the Director-General, building on the work already under way, to undertake a broad consultative process to develop global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections, for the period 2022–2030, as appropriate, in full consultation with Member States,³ taking into consideration the relevant strategies of UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria, and taking into account the views of all relevant stakeholders, ensuring that the health sector strategies remain based on qualitative and quantitative scientific evidence for the achievement of commitments for HIV, viral hepatitis and sexually transmitted infections, including Sustainable Development Goal target 3.3 and other related goals and targets, for consideration by the Seventy-fifth World Health Assembly in 2022, through the Executive Board at its 150th session.

(Seventh plenary meeting, 31 May 2021)

¹ Document A74/9.

² See Annex 4 for the financial and administrative implications for the Secretariat of this decision.

³ And, where applicable, regional economic integration organizations.

WHA74(21) Process for the election of the Director-General of the World Health Organization: candidates' statements and travel support¹

The Seventy-fourth World Health Assembly, having considered the report on the process for the election of the Director-General of the World Health Organization,²

Decided:

(1) that, in respect of the present and subsequent elections, candidates nominated by the Executive Board for the post of Director-General of the World Health Organization shall address the Health Assembly before the vote for the appointment of the Director-General, on the understanding that:

- (a) statements shall be limited to a maximum of 15 minutes each;
- (b) the order of statements shall be decided by lot;
- (c) there shall be no questions and answers after statements;
- (d) statements shall be webcast on the WHO website in all WHO official languages;

(2) that paragraph 1 shall not apply in the event that only one candidate is nominated by the Executive Board for the post of Director-General;

(3) that financial travel support, consisting of an economy-class airline ticket and a per diem for the time necessary for the interview, shall be provided to all candidates participating in the candidates' forums.

(Seventh plenary meeting, 31 May 2021)

WHA74(22) Process for the election of the Director-General of the World Health Organization: contingency arrangements¹

The Seventy-fourth World Health Assembly, having considered the report on the process for the election of the Director-General of the World Health Organization: contingency arrangements,³

Decided:

(1) that, in the event that the Seventy-fifth World Health Assembly were to be held in person, the secret ballot vote for the appointment of the Director-General would be conducted following a paper-based system, in accordance with decision WHA73(16) (2020);

(2) that, in the event that limitations to physical meetings preclude the holding of the Seventy-fifth World Health Assembly as envisaged, the appointment of the Director-General shall take place in accordance with the contingency arrangements decided by the Executive Board,

¹ See Annex 4 for the financial and administrative implications for the Secretariat of this decision.

² Document A74/24.

³ Document A74/24 Add.2.

through a written silence procedure, based on a proposal by the Officers of the Board, following consultation with all Member States.

(Seventh plenary meeting, 31 May 2021)

WHA74(23) Appointment of representatives to the WHO Staff Pension Committee

The Seventy-fourth World Health Assembly,

Decided:

(1) to reappoint Ms Yanjmaa Binderiya of the delegation of Mongolia as an alternate member of the WHO Staff Pension Committee for a three-year term until the closure of the Seventy-seventh World Health Assembly in May 2024;

(2) to reappoint Dr Kai Zaehle of the delegation of Germany as an alternate member of the WHO Staff Pension Committee for a three-year term until the closure of the Seventy-seventh World Health Assembly in May 2024.

(Seventh plenary meeting, 31 May 2021)

WHA74(24) WHO global strategy on health, environment and climate change: the transformation needed to improve lives and well-being sustainably through healthy environments

The Seventy-fourth World Health Assembly, having considered the report on the WHO global strategy on health, environment and climate change,¹

Decided to request the Director-General to report to the Seventy-sixth, Seventy-eighth and Eighty-second World Health Assemblies on progress made in the implementation of the WHO global strategy.

(Seventh plenary meeting, 31 May 2021)

WHA74(25) The role of the health sector in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond²

The Seventy-fourth World Health Assembly, having considered the report on the role of the health sector in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond,³

Decided to request the Director-General to report to the Seventy-sixth World Health Assembly in 2023 on progress made in implementing the road map, as well as on actions undertaken by the Secretariat to update the road map in the light of the outcome of the intersessional process to prepare recommendations regarding the Strategic Approach and the sound management of chemicals and waste beyond 2020.

(Seventh plenary meeting, 31 May 2021)

¹ Document A74/41.

² See Annex 4 for the financial and administrative implications for the Secretariat of this decision.

³ Document A74/42.

WHA74(26) Report of the External Auditor

The Seventy-fourth World Health Assembly, having considered the report of the External Auditor to the Health Assembly;¹ and having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-fourth World Health Assembly,²

Decided to accept the report of the External Auditor to the Health Assembly.

(Seventh plenary meeting, 31 May 2021)

WHA74(27) WHO programme and financial reports for 2020–2021, including audited financial statements for 2020

The Seventy-fourth World Health Assembly, having considered the WHO Results Report for the Programme budget 2020–2021: mid-term review,³ and the audited financial statements for the year ended 31 December 2020;⁴ and having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-fourth World Health Assembly,⁵

Decided to accept the WHO Results Report for the Programme budget 2020–2021: mid-term review, and the audited financial statements for the year ended 31 December 2020.

(Seventh plenary meeting, 31 May 2021)

WHA74(28) Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution:situation in respect of 2020

The Seventy-fourth World Health Assembly, having considered the report on the status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution;⁶ and having also considered the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-fourth World Health Assembly,⁷

Decided:

(1) to refer to the 150th session of the Executive Board in January 2022, through the Programme, Budget and Administration Committee, consideration of the status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution; and, with respect to the situation in 2020, and in accordance with Article 29 of the WHO Constitution, to delegate to the 150th session of the Executive Board the power to suspend the voting privileges of Member States

¹ Document A74/34.

² Document A74/51.

³ Document A74/28.

⁴ Document A74/29.

⁵ Document A74/47.

⁶ Document A74/31.

⁷ Document A74/48.

in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution;

(2) to request the Director-General to submit to the Executive Board at its 150th session, through the Programme, Budget and Administration Committee, a report providing an update on the situation as well as an updated draft resolution, as appropriate.

(Seventh plenary meeting, 31 May 2021)

WHA74(29) Assessment of the Faroe Islands

The Seventy-fourth World Health Assembly, having considered the report by the Director-General on the assessment of the Faroe Islands,¹ and having also considered the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-fourth World Health Assembly,²

Decided:

(1) that the assessment of the Faroe Islands shall be set on the basis of a notional assessment of the minimum rate of 0.001%;

(2) that for 2021, assessment shall be allocated at one twelfth of the rate per full calendar month of associate membership;

(3) that for 2021, if any, the amount shall be recorded as miscellaneous income;

(4) that, as the United Nations scale of assessment is expected to be updated in December 2021, the impact of the assessment of Faroe Islands will be fully reflected in the WHO scale of assessment for 2022–2023 at the Seventy-fifth World Health Assembly in 2022.

(Seventh plenary meeting, 31 May 2021)

WHA74(30) Selection of the country in which the Seventy-fifth World Health Assembly would be held

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

(Seventh plenary meeting, 1 June 2021)

¹ Document A74/33.

² Document A74/50.

ANNEXES

ANNEX 1

ORIGINAL VERSION: FRENCH

Agreement between the World Health Organization and the International Organisation of la Francophonie¹

[A74/44, Annex – 10 May 2021]

The World Health Organization (hereafter “WHO”); and

The International Organisation of La Francophonie (hereafter “OIF”);

Hereafter individually and collectively termed “the Party” and “the Parties”;

Considering that the objective of WHO is the attainment by all peoples of the highest possible level of health, and to this end WHO is the directing and coordinating authority for health-related work with an international dimension;

Considering that OIF is a major stakeholder in implementing international instruments of a universal nature with respect to the promotion and protection of basic rights including the right to health; and that it ensures, through advocacy and mobilization, the effective implementation of resolutions and declarations with respect to well-being and health adopted by its Member States and Governments;

Recalling that WHO and OIF concluded a Memorandum of Understanding on 14 April 2021 to intensify their cooperation and collaboration in the area of advocacy and mobilization of francophone States and Governments regarding questions of public health;

Desiring to coordinate their efforts within their respective mandates and in accordance with the Constitution of WHO and the Charter of La Francophonie;

Wishing to strengthen their cooperation on the basis of regular consultations;

Have agreed as follows:

Article 1

Object and areas of cooperation

1. The object of this Agreement is to facilitate and reinforce cooperation and collaboration between the Parties on all questions in the area of health that relate to the activities and commitments of the Parties.

¹ See resolution WHA74.11.

2. Within the scope of their respective mandates and programmes of work, the Parties agree to a general strengthening of their cooperation, specifically as regards the WHO Academy; universal health coverage and primary health care; malaria; and any other area of common interest.

Article 2

Reciprocal representation

1. On the basis of reciprocity, OIF is invited to represent itself at sessions of the World Health Assembly and the Executive Board in accordance with the rules and decisions adopted by these bodies and, as appropriate, any other meetings held under the auspices of WHO in the deliberations of which OIF could participate, without the right to vote, on agenda items of concern to it.
2. On the basis of reciprocity, WHO is invited to represent itself at Summits of La Francophonie and, as appropriate, any other meetings held under the auspices of OIF in the deliberations of which WHO could participate, without the right to vote, on agenda items of concern to it.

Article 3

Sharing of information

The Parties agree to exchange, by whatever means, information concerning their activities which they deem appropriate, subject to their existing policies, respect for the sovereign rights of their Member States and Governments, confidentiality obligations and the protection of commercial, contractual or other secrets.

Article 4

Privileges and immunities

No provision of this Agreement shall be interpreted or considered as a renunciation, limitation, waiver or modification of the privileges and immunities enjoyed by the Parties under international agreements and national laws applicable to them.

Article 5

Entry into force, amendment and denunciation

1. This Agreement is valid from the date of its signature by the Director-General of WHO and the Secretary General of La Francophonie, subject to approval by the World Health Assembly.
2. This Agreement may be amended at any time by mutual written consent of the Parties.
3. Either Party may denounce this Agreement at any time by serving written notice on the other Party of its intent to do so six (6) months in advance. The denunciation of the Agreement shall not prejudice any activities being conducted under the terms of the Agreement at the time of said denunciation.

Article 6

Settlement of differences

Any difference, dispute or litigation arising from the interpretation or application of this Agreement shall be settled amicably through negotiation between the Parties. If attempted negotiation yields no result, either Party may request that the difference be submitted for arbitration in accordance with the currently applicable Arbitration Rules of the United Nations Commission on International Trade Law.

IN WITNESS WHEREOF, this Agreement is done and signed at Geneva on [.....], in two copies, in the English and French languages, both texts being equally authentic. In the event of any difference of interpretation of this Agreement, the French text is authoritative.

For the International Organisation of La
Francophonie

For the World Health Organization

Secretary General of La Francophonie
Louise Mushikiwabo

Director-General
Tedros Adhanom Ghebreyesus

ANNEX 2

Rights and privileges of participation of the Holy See¹

The rights and privileges of participation of the Holy See shall be effected through the following modalities, without prejudice to the existing rights and privileges within the World Health Organization:

1. the right to participate in the general debate of the Health Assembly;
2. the right to make interventions and to be inscribed on the list of speakers, without prejudice to the priority of Member States, at any plenary meeting of the Health Assembly, in its main committees, in the Executive Board as well as in the Programme, Budget and Administration Committee of the Executive Board, after the last Member State inscribed on the list;
3. the right of reply;
4. the right to raise points of order relating to any proceedings involving the Holy See, provided that the right to raise such a point of order shall not include the right to challenge the decision of the presiding officer;
5. the right to cosponsor draft resolutions and decisions that make reference to the Holy See; such draft resolutions and decisions shall be put to a vote only upon request from a Member State;
6. seating for the Holy See shall be arranged immediately after Member States; and
7. the Holy See shall not have the right to vote or to put forward candidates.

¹ See resolution WHA74.12.

ANNEX 3

RECOMMENDATIONS ON FEASIBLE GLOBAL TARGETS FOR EFFECTIVE COVERAGE OF REFRACTIVE ERROR AND EFFECTIVE COVERAGE OF CATARACT SURGERY TO BE ACHIEVED BY 2030¹

1. The recommended feasible global target for effective coverage of refractive error is:
 - a 40 percentage point increase in effective coverage of refractive error by 2030:
 - countries with a baseline effective coverage rate of 60% or higher should strive for universal coverage;
 - countries should aim to achieve an equal increase in effective coverage of near and distance refractive error in all relevant population subgroups, independent of baseline estimates.
2. The recommended feasible global target for effective coverage of cataract surgery is:
 - a 30 percentage point increase in effective coverage of cataract surgery by 2030:
 - countries with a baseline effective coverage rate of 70% or higher should strive for universal coverage;
 - countries should aim to achieve an equal increase in effective coverage of cataract surgery in all relevant population subgroups, independent of baseline estimates.

(Seventh plenary meeting, 31 May 2021)

¹ See decision WHA74(12).

ANNEX 4

Financial and administrative implications for the Secretariat of resolutions and decisions adopted by the Health Assembly

Resolution WHA74.4	Reducing the burden of noncommunicable diseases through strengthening prevention and control of diabetes
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this resolution would contribute:	<p>1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages</p> <p>1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results</p> <p>1.3.2. Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems</p> <p>3.2.1. Countries enabled to develop and implement technical packages to address risk factors through multisectoral action</p>
2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Not applicable.
4. Estimated time frame (in years or months) to implement the resolution:	10 years.
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	US\$ 94.5 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 1.5 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Not applicable.

3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:
US\$ 14.2 million.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:
2024–2025
US\$ 28.4 million.
2026–2027
US\$ 22.6 million.
2028–2029
US\$ 27.8 million.
Total: US\$ 78.8 million.
5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions
– Resources available to fund the resolution in the current biennium:
US\$ 1.5 million.
– Remaining financing gap in the current biennium:
Not applicable.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:
Not applicable.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	0.0	–	0.0	–	–	–	0.4	0.4
	Activities	0.4	–	0.4	–	–	–	0.3	1.1
	Total	0.4	–	0.4	–	–	–	0.7	1.5
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	0.60	0.40	0.50	0.60	0.50	0.40	0.62	3.62
	Activities	1.50	1.70	1.60	1.50	1.60	1.70	0.98	10.58
	Total	2.10	2.10	2.10	2.10	2.10	2.10	1.60	14.2
Future bienniums resources to be planned	Staff	1.80	1.20	1.50	1.80	1.50	1.20	1.88	10.88
	Activities	10.82	10.82	10.82	10.82	10.82	10.82	3.00	67.92
	Total	12.62	12.02	12.32	12.62	12.32	12.02	4.88	78.80

Resolution WHA74.5 Oral health	
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this resolution would contribute:	<p>1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages</p> <p>1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results</p> <p>1.3.2. Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems</p> <p>1.3.4. Research and development agenda defined and research coordinated in line with public health priorities</p> <p>3.1.2. Countries enabled to address environmental determinants of health, including climate change</p> <p>3.2.1. Countries enabled to develop and implement technical packages to address risk factors through multisectoral action</p>
2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Not applicable.
4. Estimated time frame (in years or months) to implement the resolution:	Seven years.
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	<p>Biennium 2020–2021: US\$ 1.7 million.</p> <p>Biennium 2022–2023: US\$ 3.6 million.</p> <p>Period 2024–2027: US\$ 7.2 million.</p> <p>Total cost: US\$ 12.5 million over seven years.</p>
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 1.7 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Zero.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	US\$ 3.6 million.

4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:
US\$ 7.2 million.
5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions
– Resources available to fund the resolution in the current biennium:
US\$ 1.05 million.
– Remaining financing gap in the current biennium:
US\$ 0.65 million.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:
On course to raise US\$ 0.2 million in the current biennium.

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		
2020–2021 resources already planned	Staff	0.6	0.0	0.0	0.0	0.0	0.0	1.1	1.7
	Activities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total	0.6	0.0	0.0	0.0	0.0	0.0	1.1	1.7
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	0.6	0.0	0.4	0.0	0.4	0.0	1.4	2.8
	Activities	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.8
	Total	0.7	0.1	0.5	0.1	0.5	0.1	1.6	3.6
Future bienniums resources to be planned	Staff	1.2	0.0	0.8	0.0	0.8	0.0	2.8	5.6
	Activities	0.2	0.2	0.2	0.2	0.2	0.2	0.4	1.6
	Total	1.4	0.2	1.0	0.2	1.0	0.2	3.2	7.2

Resolution WHA74.6	Strengthening local production of medicines and other health technologies to improve access
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this resolution would contribute:	
	1.3.2. Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems
	1.3.3. Country and regional regulatory capacity strengthened, and supply of quality-assured and safe health products improved
	2.1.2. Capacities for emergency preparedness strengthened in all countries
	2.3.3. Essential health services and systems maintained and strengthened in fragile, conflict and vulnerable settings

2.	Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2020–2021: Not applicable.
3.	Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021: Not applicable.
4.	Estimated time frame (in years or months) to implement the resolution: 10 years from 2021 to 2030.
B. Resource implications for the Secretariat for implementation of the resolution	
1.	Total resource requirements to implement the resolution, in US\$ millions: US\$ 69.54 million for the period 2021–2030.
2.a.	Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions: US\$ 5.16 million.
2.b.	Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions: Not applicable.
3.	Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions: US\$ 13.32 million.
4.	Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions: US\$ 51.06 million for the remaining seven years.
5.	Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions <ul style="list-style-type: none"> – Resources available to fund the resolution in the current biennium: US\$ 0.56 million. – Remaining financing gap in the current biennium: US\$ 4.60 million. – Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium: Discussions are ongoing with donors to mobilize resources as well as to redistribute underutilized funds within the existing programme budget.

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		
2020–2021 resources already planned	Staff	0.07	0.12	0.05	0.08	0.04	0.06	1.09	1.51
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	3.65	3.65
	Total	0.07	0.12	0.05	0.08	0.04	0.06	4.74	5.16
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	0.30	0.50	0.21	0.34	0.18	0.26	4.72	6.51
	Activities	0.18	0.18	0.18	0.18	0.18	0.18	5.73	6.81
	Total	0.48	0.68	0.39	0.52	0.36	0.44	10.45	13.32
Future bienniums resources to be planned	Staff	1.08	1.82	0.78	1.23	0.66	0.93	25.78	32.28
	Activities	0.70	0.70	0.70	0.70	0.70	0.70	14.58	18.78
	Total	1.78	2.52	1.48	1.93	1.36	1.63	40.36	51.06

Resolution WHA74.7 Strengthening WHO preparedness for and response to health emergencies**A. Link to the approved Programme budget 2020–2021****1. Output(s) in the approved Programme budget 2020–2021 to which this resolution would contribute:**

- 2.1.1. All-hazards emergency preparedness capacities in countries assessed and reported
- 2.1.2. Capacities for emergency preparedness strengthened in all countries
- 2.1.3. Countries operationally ready to assess and manage identified risks and vulnerabilities
- 2.2.1. Research agendas, predictive models and innovative tools, products and interventions available for high-threat health hazards
- 2.2.2. Proven prevention strategies for priority pandemic-/epidemic-prone diseases implemented at scale
- 2.2.3. Mitigate the risk of the emergence and re-emergence of high-threat pathogens
- 2.3.1. Potential health emergencies rapidly detected, and risks assessed and communicated
- 2.3.2. Acute health emergencies rapidly responded to, leveraging relevant national and international capacities
- 2.3.3. Essential health services and systems maintained and strengthened in fragile, conflict and vulnerable settings
- 4.1.1. Countries enabled to strengthen data, analytics and health information systems to inform policy and deliver impacts
- 4.1.3. Strengthened evidence base, prioritization and uptake of WHO generated norms and standards and improved research capacity and the ability to effectively and sustainably scale up innovations, including digital technology, in countries

2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2020–2021:

Not applicable.

3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:

Coordination of the Working Group process to strengthen preparedness for and response to health emergencies.

4. Estimated time frame (in years or months) to implement the resolution:	Two and a half years (until end of 2023).
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	US\$ 1477.8 million. Please note that this covers the estimated costs under strategic priority 2 and strategic priority 4 that can be determined at this stage with a reasonable level of certainty. Additional costs for strategic priority 1 and strategic priority 3 will need to be costed based on the outcome of the work of the Working Group.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 192.1 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 5.0 million.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	US\$ 1280.7 million.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:	Not applicable.
5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions	<ul style="list-style-type: none"> – Resources available to fund the resolution in the current biennium: US\$ 197.1 million. – Remaining financing gap in the current biennium: Zero. – Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium: Not applicable.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	24.5	8.1	5.9	5.6	12.2	7.0	35.6	98.9
	Activities	32.5	13.6	8.1	4.0	11.0	8.1	15.9	93.2
	Total	57.0	21.7	14.0	9.6	23.2	15.1	51.5	192.1
2020–2021 additional resources	Staff	–	–	–	–	–	–	2.0	2.0
	Activities	–	–	–	–	–	–	3.0	3.0
	Total	–	–	–	–	–	–	5.0	5.0
2022–2023 resources to be planned	Staff	237.9	27.5	31.2	38.2	120.1	38.8	263.6	757.3
	Activities	135.0	50.0	40.6	35.3	103.3	61.9	97.3	523.4
	Total	372.9	77.5	71.8	73.5	223.4	100.7	360.9	1 280.7
Future bienniums resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–

Resolution WHA74.8	The highest attainable standard of health for persons with disabilities
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this resolution would contribute:	<p>1.1.3. Countries enabled to strengthen their health systems to address population-specific health needs and barriers to equity across the life course</p> <p>1.3.4. Research and development agenda defined and research coordinated in line with public health priorities</p> <p>2.1.3. Countries operationally ready to assess and manage identified risks and vulnerabilities</p> <p>3.1.2. Countries enabled to address environmental determinants of health, including climate change</p> <p>4.1.1. Countries enabled to strengthen data, analytics and health information systems to inform policy and deliver impacts</p> <p>4.2.6. “Leave no one behind” approach focused on equity, gender and human rights progressively incorporated and monitored</p>
2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Not applicable.
4. Estimated time frame (in years or months) to implement the resolution:	Five years.
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	US\$ 15 million over five years.

2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 2 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Zero.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	US\$ 5 million.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:	Biennium 2024–2025: US\$ 8 million.
5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions	
– Resources available to fund the resolution in the current biennium:	US\$ 1 million.
– Remaining financing gap in the current biennium:	US\$ 1 million.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:	On course to raise US\$ 0.5 million in the current biennium and there are ongoing efforts to raise an additional US\$ 0.5 million.

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		
2020–2021 resources already planned	Staff	–	–	–	–	–	–	1.6	1.6
	Activities	–	–	–	–	–	–	0.4	0.4
	Total	–	–	–	–	–	–	2.0	2.0
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	0.2	0.2	0.4	0.2	0.3	0.4	0.8	2.5
	Activities	0.3	0.3	0.3	0.3	0.3	0.3	0.7	2.5
	Total	0.5	0.5	0.7	0.5	0.6	0.7	1.5	5.0
Future bienniums resources to be planned	Staff	0.6	0.2	0.4	0.2	0.4	0.6	0.8	3.2
	Activities	0.9	0.3	0.6	0.3	0.6	0.9	1.2	4.8
	Total	1.5	0.5	1.0	0.5	1.0	1.5	2.0	8.0

Resolution WHA74.9	Recommitting to accelerate progress towards malaria elimination
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this resolution would contribute:	<p>1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages</p> <p>1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results</p>
2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Not applicable.
4. Estimated time frame (in years or months) to implement the resolution:	Seven years. The Secretariat is requested to provide a final status report to the Eighty-first World Health Assembly in 2028.
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	US\$ 417.40 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 27.60 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Not applicable.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	US\$ 114.40 million.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:	US\$ 275.40 million.
5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions	<p>– Resources available to fund the resolution in the current biennium:</p> <p>US\$ 27.60 million.</p> <p>– Remaining financing gap in the current biennium:</p> <p>Zero.</p> <p>– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</p> <p>Not applicable.</p>

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		
2020–2021 resources already planned	Staff	7.60	0.20	2.00	0.20	1.00	2.20	5.00	18.20
	Activities	3.90	0.20	1.00	0.10	0.50	1.10	2.60	9.40
	Total	11.50	0.40	3.00	0.30	1.50	3.30	7.60	27.60
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	31.50	0.80	8.40	0.70	4.10	9.20	20.60	75.30
	Activities	16.20	0.80	4.30	0.40	2.10	4.70	10.60	39.10
	Total	47.70	1.60	12.70	1.10	6.20	13.90	31.20	114.40
Future bienniums resources to be planned	Staff	75.70	2.00	20.30	1.60	9.90	22.10	49.50	181.10
	Activities	39.00	2.00	10.50	0.80	5.10	11.40	25.50	94.30
	Total	114.70	4.00	30.80	2.40	15.00	33.50	75.00	275.40

Resolution WHA74.14	Protecting, safeguarding and investing in the health and care workforce
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this resolution would contribute:	1.1.5. Countries enabled to strengthen their health workforce
2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Not applicable.
4. Estimated time frame (in years or months) to implement the resolution:	Nine and a half years (2021–2030).
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	US\$ 440.45 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 2.07 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Not applicable.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	US\$ 94.46 million.

4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:	US\$ 343.92 million.
5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions	
– Resources available to fund the resolution in the current biennium:	US\$ 2.07 million.
– Remaining financing gap in the current biennium:	Zero.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:	Not applicable.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	0.13	0.11	0.10	0.12	0.10	0.11	0.29	0.97
	Activities	0.10	0.10	0.10	0.10	0.10	0.10	0.50	1.10
	Total	0.23	0.21	0.20	0.22	0.20	0.21	0.79	2.07
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	20.42	2.05	4.01	1.47	5.99	2.69	13.95	50.59
	Activities	16.07	3.61	3.97	1.77	4.66	4.15	9.64	43.87
	Total	36.49	5.66	7.99	3.24	10.65	6.84	23.59	94.46
Future bienniums resources to be planned	Staff	74.34	7.47	14.61	5.34	21.83	9.80	50.79	184.18
	Activities	58.52	13.13	14.47	6.45	16.97	15.11	35.09	159.74
	Total	132.86	20.60	29.08	11.80	38.79	24.91	85.88	343.92

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

Resolution WHA74.15 Strengthening nursing and midwifery: investments in education, jobs, leadership and service delivery	
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this resolution would contribute:	1.1.5. Countries enabled to strengthen their health workforce
2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Not applicable.
4. Estimated time frame (in years or months) to implement the resolution:	Four years (2021–2025).
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	US\$ 34.07 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 1.50 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Not applicable.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	US\$ 14.48 million.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:	US\$ 18.09 million.
5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions	
– Resources available to fund the resolution in the current biennium:	US\$ 1.50 million.
– Remaining financing gap in the current biennium:	Zero.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:	Not applicable.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	0.13	0.11	0.10	0.12	0.10	0.11	0.00	0.68
	Activities	0.10	0.10	0.10	0.10	0.10	0.10	0.22	0.82
	Total	0.23	0.21	0.20	0.22	0.20	0.21	0.22	1.50
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	0.53	0.46	0.40	0.87	0.39	0.45	0.53	3.63
	Activities	2.60	1.55	0.80	1.50	1.05	1.35	2.00	10.85
	Total	3.13	2.01	1.20	2.37	1.44	1.80	2.53	14.48
Future bienniums resources to be planned	Staff	0.66	0.58	0.50	1.08	0.49	0.56	0.66	4.53
	Activities	3.25	1.94	1.00	1.88	1.31	1.69	2.50	13.56
	Total	3.91	2.51	1.50	2.96	1.80	2.25	3.16	18.09

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

Resolution WHA74.16 Social determinants of health	
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this resolution would contribute:	3.1.1. Countries enabled to address social determinants of health across the life course
2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Not applicable.
4. Estimated time frame (in years or months) to implement the resolution:	Two years.
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	Total cost: US\$ 5.08 million (staff US\$ 2.78 million, activities US\$ 2.3 million).
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 2.47 million is planned for in the approved Programme budget 2020–2021 that is applicable to staff costs and activities for development of a global report on social determinants of health and related information gathering on best practices for addressing the social determinants of health, as well as for consolidating information on social determinants of health indicators.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Not applicable.

3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:
US\$ 2.61 million.
Regions: to cover partial costs of staff at professional level with international expertise in social determinants of health, with knowledge of the respective region.
Headquarters: staff requirements at professional level to provide support to WHO's work on the social determinants of health, with a small component for general service staff capacity.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:
Not applicable.
5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions
– Resources available to fund the resolution in the current biennium:
US\$ 2.47 million.
– Remaining financing gap in the current biennium:
Not applicable.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:
Not applicable.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	0.16	0.13	0.13	0.13	0.12	0.14	0.56	1.37
	Activities	0.13	0.13	0.13	0.12	0.12	0.12	0.35	1.10
	Total	0.29	0.26	0.26	0.25	0.24	0.26	0.91	2.47
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	0.17	0.13	0.13	0.14	0.12	0.14	0.58	1.41
	Activities	0.12	0.13	0.12	0.13	0.13	0.12	0.45	1.20
	Total	0.29	0.26	0.25	0.27	0.25	0.26	1.03	2.61
Future bienniums resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–

Resolution WHA74.17	Ending violence against children through health systems strengthening and multisectoral approaches
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this resolution would contribute:	3.1.1. Countries enabled to address social determinants of health across the life course
2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Not applicable.
4. Estimated time frame (in years or months) to implement the resolution:	Nine and a half years.
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	US\$ 26.03 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 1.73 million. Composed of: <ul style="list-style-type: none"> – Staff costs at headquarters: 100% of existing staff posts in the Violence Prevention Unit for seven months. – Staff costs at regional offices: Six 100% P4 staff posts for seven months. – Activity capacity development, normative work and training: US\$ 0.01 million (headquarters) and US\$ 0.06 million (per region).
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Not applicable.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	US\$ 5.06 million. Composed of: <ul style="list-style-type: none"> – Staff costs at headquarters: 100% of existing staff posts in the Violence Prevention Unit. – Staff costs at regional offices: Six 100% P4 staff posts. – Activity capacity development, normative work and training: US\$ 0.3 million (headquarters) and US\$ 0.06 million (per region).

4.	<p>Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</p> <p>US\$ 19.24 million.</p> <p><u>For 2024–2030</u></p> <p>Staff costs at headquarters: 100% of existing staff posts in the Violence Prevention Unit.</p> <p>Staff costs at regional offices: Six 100% P4 staff posts.</p> <p>Activity capacity development, normative work and training: US\$ 0.30 million (headquarters) and US\$ 0.15 million (per region).</p> <p><u>Additional one-off costs for the period 2024–2026</u></p> <p>Activity development and dissemination of global status report on preventing violence against children 2025: US\$ 1.0 million (headquarters) and US\$ 0.02 million (per region).</p> <p><u>One-off costs for the period 2029–2030</u></p> <p>Activity development and dissemination of global status report on preventing violence against children 2030: US\$ 1.0 million (headquarters) and US \$0.02 (per region).</p>
5.	<p>Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions</p> <p>– Resources available to fund the resolution in the current biennium:</p> <p>US\$ 0.96 million (based on balance remaining from current awards to be spent in 2021).</p> <p>– Remaining financing gap in the current biennium:</p> <p>US\$ 0.77 million.</p> <p>– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</p> <p>Not applicable.</p>

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		
2020–2021 resources already planned	Staff	0.15	0.13	0.12	0.14	0.11	0.13	0.49	1.27
	Activities	0.06	0.06	0.06	0.06	0.06	0.06	0.10	0.46
	Total	0.21	0.19	0.18	0.20	0.17	0.19	0.59	1.73
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	0.52	0.46	0.40	0.49	0.39	0.45	1.69	4.40
	Activities	0.06	0.06	0.06	0.06	0.06	0.06	0.30	0.66
	Total	0.58	0.52	0.46	0.55	0.45	0.51	1.99	5.06
Future bienniums resources to be planned	Staff	1.87	1.64	1.45	1.75	1.40	1.60	6.09	15.80
	Activities	0.19	0.19	0.19	0.19	0.19	0.19	2.30	3.44
	Total	2.06	1.83	1.64	1.94	1.59	1.79	8.39	19.24

Decision WHA74(9)	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan
A. Link to the approved Programme budget 2020–2021	
<p>1. Output(s) in the approved Programme budget 2020–2021 to which this decision would contribute:</p> <p>2.3.1. Potential health emergencies rapidly detected, and risks assessed and communicated</p> <p>2.3.3. Essential health services and systems maintained and strengthened in fragile, conflict and vulnerable settings</p> <p>4.2.1. Leadership, governance and external relations enhanced to implement GPW 13 and drive impact in an aligned manner at the country level, on the basis of strategic communications and in accordance with the Sustainable Development Goals in the context of United Nations reform</p> <p>4.2.4. Planning, allocation of resources, monitoring and reporting based on country priorities, carried out to achieve country impact, value-for-money and the strategic priorities of GPW 13</p> <p>4.3.4. Safe and secure environment with efficient infrastructure maintenance, cost-effective support services and responsive supply chain, including duty of care</p>	
<p>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2020–2021:</p> <p>Not applicable.</p>	
<p>3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:</p> <p>Not applicable.</p>	
<p>4. Estimated time frame (in years or months) to implement the decision:</p> <p>Seven months (November 2021–May 2022).</p>	
B. Resource implications for the Secretariat for implementation of the decision	
<p>1. Total resource requirements to implement the decision, in US\$ millions:</p> <p>US\$ 14 million.</p>	
<p>2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:</p> <p>US\$ 4 million (cost for two months in 2021: November–December 2021).</p>	
<p>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:</p> <p>Not applicable.</p>	
<p>3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:</p> <p>US\$ 10 million (cost for five months in 2022: January–March 2022).</p>	

4.	Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:
	Not applicable.
5.	Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions
	– Resources available to fund the decision in the current biennium:
	US\$ 4.0 million.
	– Remaining financing gap in the current biennium:
	Not applicable.
	– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:
	Not applicable.

GPW 13: Thirteenth General Programme of Work, 2019–2023.

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		
2020–2021 resources already planned	Staff	–	–	–	–	0.8	–	–	0.8
	Activities	–	–	–	–	3.2	–	–	3.2
	Total	–	–	–	–	4.0	–	–	4.0
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	–	–	–	–	2.0	–	–	2.0
	Activities	–	–	–	–	8.0	–	–	8.0
	Total	–	–	–	–	10.0	–	–	10.0
Future bienniums resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–

Decision WHA74(10)	Follow-up of the Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this decision would contribute:	
	1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results
	3.2.1. Countries enabled to develop and implement technical packages to address risk factors reduced through multisectoral action

2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2020–2021:
Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:
Not applicable.
4. Estimated time frame (in years or months) to implement the decision:
14 months. Development of a road map 2023–2030 for the WHO’s global action plan for the prevention and control of noncommunicable diseases 2013–2030 (February 2021–May 2022). Development of an options paper for the WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases (February–December 2021).
B. Resource implications for the Secretariat for implementation of the decision
1. Total resource requirements to implement the decision, in US\$ millions:
US\$ 2.2 million (staff US\$ 1.15 million, activities US\$ 1.05 million).
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:
US\$ 2.1 million (staff US\$ 1.1 million, activities US\$ 1.0 million).
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:
Not applicable.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:
US\$ 0.1 million.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:
Not applicable.
5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions
– Resources available to fund the decision in the current biennium:
US\$ 2.1 million.
– Remaining financing gap in the current biennium:
Zero.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:
Not applicable.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	0.15	0.10	0.10	0.10	0.15	0.10	0.40	1.10
	Activities	0.10	0.10	0.10	0.10	0.10	0.10	0.40	1.00
	Total	0.25	0.20	0.20	0.20	0.25	0.20	0.80	2.10
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	–	–	–	–	–	–	0.05	0.05
	Activities	–	–	–	–	–	–	0.05	0.05
	Total	–	–	–	–	–	–	0.10	0.10
Future bienniums resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–

Decision WHA74(11) The role of the global coordination mechanism on the prevention and control of noncommunicable diseases in WHO's work on multistakeholder engagement for the prevention and control of noncommunicable diseases	
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this decision would contribute:	3.2.2. Multisectoral determinants and risk factors addressed through engagement with public and private sectors, as well as civil society
2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Not applicable.
4. Estimated time frame (in years or months) to implement the decision:	10 years (2021–2031).
B. Resource implications for the Secretariat for implementation of the decision	
1. Total resource requirements to implement the decision, in US\$ millions:	US\$ 21.55 million (staff: US\$ 10.95 million, activities: US\$ 10.6 million).
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 3.25 million (staff: US\$ 1.65 million, activities: US\$ 1.6 million).
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Not applicable.

3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:
US\$ 3.4 million (staff: US\$ 1.7 million, activities: US\$ 1.7 million).
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:
US\$ 14.9 million (staff: US\$ 7.6 million, activities: US\$ 7.3 million).
5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions
– Resources available to fund the decision in the current biennium:
US\$ 2.9 million.
– Remaining financing gap in the current biennium:
US\$ 0.35 million.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:
Not applicable.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	1.65	1.65
	Activities	0.04	0.04	0.04	0.04	0.04	0.04	1.36	1.60
	Total	0.04	0.04	0.04	0.04	0.04	0.04	3.01	3.25
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	0.06	0.06	0.04	0.06	0.04	0.04	1.40	1.70
	Activities	0.08	0.08	0.08	0.08	0.08	0.08	1.22	1.70
	Total	0.14	0.14	0.12	0.14	0.12	0.12	2.62	3.40
Future bienniums resources to be planned	Staff	0.29	0.29	0.15	0.29	0.15	0.16	6.20	7.60
	Activities	0.48	0.48	0.48	0.48	0.48	0.48	4.40	7.30
	Total	0.77	0.77	0.63	0.77	0.63	0.64	10.60	14.90

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

Decision WHA74(12) Integrated people-centred eye care, including preventable vision impairment and blindness	
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this decision would contribute:	1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results.
2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Not applicable.
4. Estimated time frame (in years or months) to implement the decision:	Nine years (the global eye care targets are set for 2030).
B. Resource implications for the Secretariat for implementation of the decision	
1. Total resource requirements to implement the decision, in US\$ millions:	Total cost of US\$ 10.5 million over nine years: – US\$ 0.3 million for the biennium 2020–2021. – US\$ 1.2 million for the biennium 2022–2023. – US\$ 9.0 million for 2024–2029.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 0.3 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Zero.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	US\$ 1.2 million.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:	US\$ 9.0 million over 2024–2029.
5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions	<ul style="list-style-type: none"> – Resources available to fund the decision in the current biennium: US\$ 0.3 million. – Remaining financing gap in the current biennium: Zero. – Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium: Not applicable.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	–	–	–	–	–	–	0.3	0.3
	Activities	–	–	–	–	–	–	0.0	0.0
	Total	–	–	–	–	–	–	0.3	0.3
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.3	0.3
	Activities	0.15	0.15	0.15	0.15	0.15	0.15	0.0	0.9
	Total	0.15	0.15	0.15	0.15	0.15	0.15	0.3	1.2
Future bienniums resources to be planned	Staff	0.4	0.3	0.3	0.3	0.3	0.4	1.0	3.0
	Activities	1.0	1.0	1.0	1.0	1.0	1.0	0.0	6.0
	Total	1.4	1.3	1.3	1.3	1.3	1.4	1.0	9.0

Decision WHA74(13) Global action on patient safety**A. Link to the approved Programme budget 2020–2021****1. Output(s) in the approved Programme budget 2020–2021 to which this decision would contribute:**

1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages

2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2020–2021:

Not applicable.

3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:

Not applicable.

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

10 years (2021–2030).

B. Resource implications for the Secretariat for implementation of the decision**1. Total resource requirements to implement the decision, in US\$ millions:**

US\$ 149.2 million (over 10 years).

2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:

US\$ 7.3 million.

2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:

Not applicable.

3.	Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions: US\$ 28.7 million.
4.	Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions: US\$ 113.2 million.
5.	Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions <ul style="list-style-type: none"> – Resources available to fund the decision in the current biennium: US\$ 3.3 million. – Remaining financing gap in the current biennium: US\$ 4.0 million. – Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium: Not applicable.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	0.3	0.3	0.2	0.3	0.2	0.3	1.6	3.2
	Activities	0.5	0.3	0.5	0.4	0.5	0.4	1.5	4.1
	Total	0.8	0.6	0.7	0.7	0.7	0.7	3.1	7.3
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	2.1	1.4	1.8	1.4	2.0	1.3	3.7	13.7
	Activities	2.4	1.3	2.3	1.7	2.2	2.0	3.1	15.0
	Total	4.5	2.7	4.1	3.1	4.2	3.3	6.8	28.7
Future bienniums resources to be planned	Staff	8.3	5.6	6.9	5.5	7.9	5.3	14.5	54.0
	Activities	9.3	5.2	8.9	6.8	8.5	8.1	12.3	59.2
	Total	17.6	10.8	15.8	12.3	16.4	13.4	26.8	113.2

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

Decision WHA74(14) Mental health preparedness for and response to the COVID-19 pandemic	
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this decision would contribute:	<p>1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results</p> <p>2.1.3. Countries operationally ready to assess and manage identified risks and vulnerabilities</p> <p>2.3.1. Potential health emergencies rapidly detected, and risks assessed and communicated</p> <p>2.3.3. Essential health services and systems maintained and strengthened in fragile, conflict and vulnerable settings</p>
2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Not applicable.
4. Estimated time frame (in years or months) to implement the decision:	Ten years.
B. Resource implications for the Secretariat for implementation of the decision	
1. Total resource requirements to implement the decision, in US\$ millions:	<p>US\$ 161.1 million (staff: US\$ 69.9 million, activities: US\$ 91.2 million).</p> <p>Please note that the costing of this decision is largely derived from the costings linked to document EB148/7 and already approved under decision EB148(3) (2021).</p>
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 10.0 million (staff: US\$ 3.9 million, activities: US\$ 6.1 million).
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Not applicable.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	US\$ 36.6 million (staff: US\$ 16.4 million, activities: US\$ 20.2 million).
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:	US\$ 114.5 million (staff: US\$ 49.6 million, activities: US\$ 64.9 million).

5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions
– Resources available to fund the decision in the current biennium: US\$ 8.5 million.
– Remaining financing gap in the current biennium: US\$ 1.5 million.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium: Not applicable.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	0.68	0.68	0.49	0.54	0.64	0.49	0.37	3.90
	Activities	0.77	0.77	0.77	0.77	0.77	0.77	1.50	6.10
	Total	1.45	1.45	1.26	1.31	1.41	1.26	1.87	10.00
2020–2021 additional resources required	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	2.73	2.73	2.13	2.33	2.53	2.13	1.80	16.40
	Activities	2.90	2.90	2.90	2.90	2.90	2.90	2.80	20.20
	Total	5.63	5.63	5.03	5.23	5.43	5.03	4.60	36.60
Future bienniums resources to be planned	Staff	7.42	7.32	7.02	7.12	7.32	7.12	6.30	49.60
	Activities	9.20	9.20	9.20	9.20	9.20	9.20	9.70	64.90
	Total	16.62	16.52	16.22	16.32	16.52	16.32	16.00	114.50

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

Decision WHA74(15) Implementation of the International Health Regulations (2005)
A. Link to the approved Programme budget 2020–2021
1. Output(s) in the approved Programme budget 2020–2021 to which this decision would contribute: 2.3.2. Acute health emergencies rapidly responded to, leveraging relevant national and international capacities
2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2020–2021: Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021: Not applicable.

4. Estimated time frame (in years or months) to implement the decision:	Two and a half years.
B. Resource implications for the Secretariat for implementation of the decision	
1. Total resource requirements to implement the decision, in US\$ millions:	US\$ 3.50 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 0.75 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Not applicable.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	US\$ 2.75 million.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:	Not applicable.
5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions	
– Resources available to fund the decision in the current biennium:	US\$ 0.75 million.
– Remaining financing gap in the current biennium:	Not applicable.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:	Not applicable.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	–	–	–	–	–	–	0.70	0.70
	Activities	–	–	–	–	–	–	0.05	0.05
	Total	–	–	–	–	–	–	0.75	0.75
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	–	–	–	–	–	–	2.50	2.50
	Activities	–	–	–	–	–	–	0.25	0.25
	Total	–	–	–	–	–	–	2.75	2.75
Future bienniums resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–

Decision WHA74(16) Special session of the World Health Assembly to consider developing a WHO convention, agreement or other international instrument on pandemic preparedness and response	
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this decision would contribute:	4.2.1. Leadership, governance and external relations enhanced to implement GPW 13 and drive impact in an aligned manner at the country level, on the basis of strategic communications and in accordance with the Sustainable Development Goals in the context of United Nations reform.
2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Convening of a special session of the World Health Assembly.
4. Estimated time frame (in years or months) to implement the decision:	Seven months (June–December 2021).
B. Resource implications for the Secretariat for implementation of the decision	
1. Total resource requirements to implement the decision, in US\$ millions:	US\$ 1.55 million, assuming a face-to-face special session of the Health Assembly (duration: three days).
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Zero.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 1.55 million.

3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:
Not applicable.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:
Not applicable.
5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions
– Resources available to fund the decision in the current biennium:
US\$ 1.55 million.
– Remaining financing gap in the current biennium:
Not applicable.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:
Not applicable.

GPW 13: Thirteenth General Programme of Work, 2019–2023.

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		
2020–2021 resources already planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 additional resources	Staff	–	–	–	–	–	–	0.15	0.15
	Activities	–	–	–	–	–	–	1.40	1.40
	Total	–	–	–	–	–	–	1.55	1.55
2022–2023 resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
Future bienniums resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–

Decision WHA74(20) The global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections	
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this decision would contribute:	<p>1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages</p> <p>1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results</p> <p>1.1.3. Countries enabled to strengthen their health systems to address population-specific health needs and barriers to equity across the life course</p> <p>1.3.2. Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems</p>
2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Not applicable.
4. Estimated time frame (in years or months) to implement the decision:	18 months.
B. Resource implications for the Secretariat for implementation of the decision	
1. Total resource requirements to implement the decision, in US\$ millions:	US\$ 1.13 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 0.77 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Not applicable.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	US\$ 0.36 million.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:	Not applicable.
5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions	<p>– Resources available to fund the decision in the current biennium:</p> <p>US\$ 0.59 million.</p> <p>– Remaining financing gap in the current biennium:</p> <p>US\$ 0.18 million.</p>

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

Not applicable.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	0.05	0.05	0.03	0.04	0.04	0.04	0.20	0.45
	Activities	0.02	0.02	0.02	0.02	0.02	0.02	0.20	0.32
	Total	0.07	0.07	0.05	0.06	0.06	0.06	0.40	0.77
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	0.02	0.02	0.01	0.02	0.01	0.02	0.10	0.20
	Activities	0.01	0.01	0.01	0.01	0.01	0.01	0.10	0.16
	Total	0.03	0.03	0.02	0.03	0.02	0.03	0.20	0.36
Future bienniums resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–

Decision WHA74(21) Process for the election of the Director-General of the World Health Organization: candidates' statements and travel support

Decision WHA74(22) Process for the election of the Director-General of the World Health Organization: contingency arrangements

A. Link to the approved Programme budget 2020–2021

1. Output(s) in the approved Programme budget 2020–2021 to which these decisions would contribute:

4.2.1. Leadership, governance and external relations enhanced to implement GPW 13 and drive impact in an aligned manner at the country level, on the basis of strategic communications and in accordance with the Sustainable Development Goals in the context of United Nations reform

2. Short justification for considering the decisions, if there is no link to the results as indicated in the approved Programme budget 2020–2021:

Not applicable.

3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:

Not applicable.

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

12 months.

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

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

Zero.

<p>2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions: Zero.</p> <p>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions: Not applicable.</p>
<p>3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions: Zero.</p>
<p>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions: Not applicable.</p>
<p>5. Level of available resources to fund the implementation of the decisions in the current biennium, in US\$ millions</p> <ul style="list-style-type: none"> – Resources available to fund the decisions in the current biennium: Not applicable. – Remaining financing gap in the current biennium: Not applicable. – Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium: Not applicable.

GPW 13: Thirteenth General Programme of Work, 2019–2023.

<p>Decision WHA74(25) The role of the health sector in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond</p>
<p>A. Link to the approved Programme budget 2020–2021</p>
<p>1. Output(s) in the approved Programme budget 2020–2021 to which this decision would contribute: 3.3.2. Global and regional governance mechanisms used to address health determinants and multisectoral risks</p>
<p>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2020–2021: Not applicable.</p>
<p>3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021: Not applicable.</p>
<p>4. Estimated time frame (in years or months) to implement the decision: Two months, in early 2023.</p>

B. Resource implications for the Secretariat for implementation of the decision	
1. Total resource requirements to implement the decision, in US\$ millions:	US\$ 0.06 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Not applicable.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Not applicable.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	US\$ 0.06 million.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:	Not applicable.
5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions	
– Resources available to fund the decision in the current biennium:	Not applicable.
– Remaining financing gap in the current biennium:	Not applicable.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:	Not applicable.

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		
2020–2021 resources already planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	–	–	–	–	–	–	0.05	0.05
	Activities	–	–	–	–	–	–	0.01	0.01
	Total	–	–	–	–	–	–	0.06	0.06
Future bienniums resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–