



WORLD HEALTH ORGANIZATION

SEVENTY-FIRST WORLD HEALTH ASSEMBLY

GENEVA, 21–26 MAY 2018

**RESOLUTIONS AND DECISIONS
ANNEXES**

GENEVA
2018

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

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PREFACE

The Seventy-first World Health Assembly was held at the Palais des Nations, Geneva, from 21 to 26 May 2018, in accordance with the decision of the Executive Board at its 141st session.¹

¹ Decision EB141(7) (2017).

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OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES¹

President

Dr Pagwesese David PARIRENYATWA
(Zimbabwe)

Vice-Presidents

Dr Francisco DUQUE III (the Philippines)
Ms Khadeeja ABDUL SAMAD ABDULLA
(Maldives)
Dr Yelzhan BIRTANOV (Kazakhstan)
Dr Djama ELMI OKIEH (Djibouti)
Dr Rafael SÁNCHEZ CÁRDENAS
(Dominican Republic)

Secretary

Dr Tedros Adhanom GHEBREYESUS,
Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Bahrain, El Salvador, Iceland, Jamaica, Lesotho, Mongolia, Nepal, Niger, Sao Tome and Principe, Serbia, Solomon Islands and Turkmenistan.

Chairman: Mr Sveinn MAGNÚSSON
(Iceland)

Vice-Chairman: Ms Ragchaa OYUNKHAND
(Mongolia)

Secretary: Ms Françoise MOURAIN-SCHUT,
Senior Legal Officer

General Committee

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the chairmen of the main committees, together with the delegates of the following Member States: Argentina, Barbados,

Botswana, Bulgaria, China, Cuba, Fiji, France, Gabon, Madagascar, Mauritania, Nigeria, Russian Federation, Somalia, Turkey, United Kingdom of Great Britain and Northern Ireland and United States of America.

Chairman: Dr Pagwesese David
PARIRENYATWA (Zimbabwe)

Secretary: Dr Tedros Adhanom
GHEBREYESUS, Director-General

MAIN COMMITTEES

Under Rule 33 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

Chairman: Mr Arun SINGHAL (India)

Vice-Chairmen: Dr Søren BROSTRØM
(Denmark) and Mrs Mónica MARTÍNEZ
MENDUIÑO (Ecuador)

Rapporteur: Dr Alain ETOUNDI MBALLA
(Cameroon)

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

Committee B

Chairman: Dr Firozuddin FERAZ (Afghanistan)

Vice-Chairmen: Dr Stewart JESSAMINE (New
Zealand) and Professor Nicolas MÉDA

Rapporteur: Dr José Eliseo ORELLANA (El
Salvador)

Secretary: Dr Clive ONDARI, Coordinator,
Safety and Vigilance

REPRESENTATIVES OF THE EXECUTIVE BOARD

Dr Asaad HAFEEZ (Pakistan)
Mr Philip DAVIES (Fiji)
Dr Josiane NIJIMBERE (Burundi)
Ms Sarah LAWLEY (Canada)

¹ In addition, the list of delegates and other participants is contained in document A71/DIV./1 Rev.2.

RESOLUTIONS AND DECISIONS

RESOLUTIONS

WHA71.1 Thirteenth General Programme of Work, 2019–2023

The Seventy-first World Health Assembly,

Having considered the draft thirteenth general programme of work, 2019–2023,¹ and welcoming its ambitious vision as expressed by the aspirational “triple billion” goals;

Noting that approval of the Thirteenth General Programme of Work, 2019–2023 does not imply approval of the financial estimate contained in document EB142/3 Add.2,

1. APPROVES the Thirteenth General Programme of Work, 2019–2023;
2. URGES Member States to support work towards achievement of the vision of the Thirteenth General Programme of Work, 2019–2023;
3. REQUESTS the Director-General:
 - (1) to use the Thirteenth General Programme of Work as the basis for the strategic direction of planning, monitoring and evaluation of WHO’s work during the period 2019–2023, and to develop programme budgets in consultation with Member States, based on a realistic assessment of income and WHO’s capacity;
 - (2) to take into consideration the changing state of global health in implementing the Thirteenth General Programme of Work, and to keep Member States informed of progress with implementation through regular updates to the governing bodies;
 - (3) to provide guidance and support to regional and country offices on the implementation of the Thirteenth General Programme of Work, taking into account different contexts;
 - (4) to provide a report to the Seventy-fifth World Health Assembly to inform potential extension to 2025 of the Thirteenth General Programme of Work in order to align with the wider United Nations planning cycle.

(Sixth plenary meeting, 25 May 2018 –
Committee A, first report)

¹ Document A71/4.

WHA71.2 Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018¹

The Seventy-first World Health Assembly,

Having considered the reports on the Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018;²

Having recognized that the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases³ has catalysed action and retains great potential for engendering progress towards Sustainable Development Goal target 3.4 (by 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being);⁴

Noting with concern that, according to WHO, each year, 15 million people between the ages of 30 and 69 years die from a noncommunicable disease and that the current levels of decline in the risk of dying prematurely from noncommunicable diseases are insufficient to attain Sustainable Development Goal target 3.4 by 2030;

Welcoming the convening of the WHO Global Conference on Noncommunicable Diseases,⁵ which was organized by Uruguay and WHO, co-chaired by Finland, the Russian Federation and Uruguay, from 18 to 20 October 2017 in Montevideo;

Welcoming also the convening of the WHO Global Dialogue on Partnerships for Sustainable Financing of Noncommunicable Disease (NCD) Prevention and Control, hosted by the Government of Denmark and WHO from 9 to 11 April 2018 in Copenhagen, recognizing the need to prioritize tackling noncommunicable diseases as an essential pillar of sustainable development and an integral part of countries' efforts towards universal health coverage;

Recalling the Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development, adopted at the 9th Global Conference on Health Promotion, held in China from 21 to 24 November 2016;

¹ See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

² Documents A71/14 and A71/14 Add.1.

³ United Nations General Assembly resolution 66/2.

⁴ United Nations General Assembly resolution 70/1.

⁵ WHO Global Conference on Noncommunicable diseases: Enhancing policy coherence between different spheres of policy making that have a bearing on attaining SDG target 3.4 on NCDs by 2030. Geneva; World Health Organization: 2018 (<http://www.who.int/nmh/events/2017/montevideo/about/en/>, accessed 18 May 2018).

Taking note that the Director-General has established a WHO Independent High-level Commission on Noncommunicable Diseases¹ and a WHO Civil Society Working Group on the third High-level Meeting of the General Assembly on NCDs;²

Recalling United Nations General Assembly resolution 72/274 (2018) on the scope, modalities, format and organization of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases,

1. WELCOMES the outcome document of the WHO Global Conference on Noncommunicable Diseases entitled “Montevideo roadmap (2018–2030) on the prevention and control of Noncommunicable Diseases as a sustainable development priority”,^{3,4} as a contribution to the preparatory process leading to the third High-level Meeting;

2. URGES Member States:⁵

(1) to continue to step up efforts on the prevention and control of noncommunicable diseases in order to attain Sustainable Development Goal target 3.4 by 2030;

(2) to actively engage in the preparations at national, regional and global levels for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018;

(3) to be represented at the level of Heads of State and Government at the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and to call for action through a concise, action-oriented outcome document;

3. REQUESTS the Director-General:

(1) to continue to support Member States, in coordination with United Nations specialized agencies, funds and programmes as well as other stakeholders, in their efforts to reduce by one third premature mortality from noncommunicable diseases through prevention and control, and to promote mental health and well-being, including by applying evidence-based multisectoral and multistakeholder approaches;

¹ WHO Independent High-level Commission on NCDs Geneva: World Health Organization: 2018 (<http://www.who.int/ncds/governance/high-level-commission/en/>, accessed 18 May 2018).

² WHO Civil Society Working Group on the third High-level Meeting of the UN General Assembly on NCDs Geneva: World Health Organization: 2018 (<http://www.who.int/ncds/governance/high-level-meetings/working-group-third-high-level-meeting/en/>, accessed 18 May 2018).

³ See Annex 1.

⁴ Clarification Statement: http://www.who.int/conferences/global-ncd-conference/USA_statement_EOP_montevideo_roadmap.pdf?ua=1, accessed 18 May 2018.

⁵ And, where applicable, regional economic integration organizations.

(2) to report to the Seventy-second World Health Assembly, through the Executive Board, on the outcomes of the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and its follow-up.

(Seventh plenary meeting, 26 May 2018 –
Committee A, second report)

WHA71.3 Preparation for a high-level meeting of the General Assembly on ending tuberculosis¹

The Seventy-first World Health Assembly,

Having considered the reports on the preparation for a high-level meeting of the General Assembly on ending tuberculosis;²

Noting with concern that tuberculosis remains the leading infectious disease killer in the world today, responsible for an estimated 1.3 million deaths and an additional 374 000 deaths among people living with HIV/AIDS in 2016, and that the epidemic, including drug-resistant tuberculosis, poses a serious threat to health security and is a priority in the response to antimicrobial resistance;

Reaffirming resolution WHA67.1 (2014) adopting the global strategy and targets for tuberculosis prevention, care and control after 2015, subsequently known as the End TB Strategy; and resolution WHA68.7 (2015) adopting the global action plan on antimicrobial resistance; as well as recalling General Assembly resolution 71/3 (2016) “Political Declaration of the High-Level Meeting of the General Assembly on Antimicrobial Resistance”;

Recalling 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 of ending the tuberculosis epidemic by 2030;

Recalling further the report submitted to the Seventieth World Health Assembly in May 2017 on the implementation of the End TB Strategy, which concluded that global, regional and country-level actions as well as investments were falling far short of those needed and that high-level global support and regional and national commitments were required; and noting that progress is slow on all three targets of the Strategy (reducing TB incidence, reducing TB mortality, and eliminating catastrophic costs among TB patients and their households);³

Recognizing that to achieve the tuberculosis targets and milestones of the Sustainable Development Goals and of the End TB Strategy, care and prevention-related actions should be reinforced, paying particular attention to vulnerable groups, taking into account national contexts and circumstances, in the context of each country’s path towards achieving universal health coverage and taking into account social, economic and environmental determinants and consequences of tuberculosis;

Welcoming the decision contained in General Assembly resolution 71/159 (2016), to hold a high-level meeting on the fight against tuberculosis in 2018;

¹ See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

² Documents A71/15, A71/16 and A71/16 Add.1.

³ Document A70/38, section E.

Welcoming also the first WHO global ministerial conference on “Ending TB in the Sustainable Development Era: A Multisectoral Response”, organized jointly with the Government of the Russian Federation and held in Moscow on 16 and 17 November 2017, and the resulting Moscow Declaration to End TB,¹ with commitments and calls to action regarding, notably: advancing the response to tuberculosis within the Sustainable Development Agenda; ensuring sufficient and sustainable financing; pursuing science, research and innovation; developing a multisectoral accountability framework; and, acting immediately to prepare for the high-level meeting of the United Nations General Assembly in 2018 on the fight against tuberculosis;

Noting the commitment made in the Moscow Declaration to End TB to support the development of the multisectoral accountability framework, and recalling in this regard resolution EB142.R3 (2018);

Welcoming the Secretariat’s report on a draft multisectoral accountability framework to accelerate progress to end tuberculosis,²

1. URGES Member States:³

(1) to support preparation for the high-level meeting of the United Nations General Assembly in 2018 on the fight against tuberculosis, including enabling high-level participation; and

(2) to pursue the implementation of all the commitments called for in the Moscow Declaration to End TB,¹ which will contribute to reaching the targets of the End TB Strategy and the Sustainable Development Goals target to end the tuberculosis epidemic;

2. CALLS UPON all international, regional and national partners, as appropriate, to pursue the actions called for in the Moscow Declaration to End TB and invite those who have not yet endorsed it to add their support;

3. REQUESTS the Director-General:

(1) to continue to support the United Nations Secretary-General and the General Assembly, upon request, in the preparation of the high-level meeting of the General Assembly in 2018 on the fight against tuberculosis;

(2) to support, together with all relevant stakeholders, the implementation of the Moscow Declaration to End TB as a direct contribution to the success of the high-level meeting of the United Nations General Assembly in 2018 on the fight against tuberculosis, and to advance tuberculosis prevention and care and the specific actions requested of WHO in the Moscow Declaration, including actions: to strengthen health systems towards achieving universal health coverage, including for tuberculosis prevention and care; to urgently support high multidrug-resistant tuberculosis (MDR-TB) burden countries in their national emergency response and to address MDR-TB as a major threat to public health security by supporting implementation of the global action plan on antimicrobial resistance, including tuberculosis-specific actions in all countries;

¹ See Annex 2.

² Documents A71/16 and A71/16 Add.1.

³ And, where applicable, regional economic integration organizations.

- (3) to continue to provide strategic and technical leadership, assistance, advice and support to Member States, as well as working with international institutions and all other relevant stakeholders, towards sufficient and sustainable financing;
- (4) to develop a global strategy for tuberculosis research and innovation, taking into consideration both ongoing and new efforts, and to make further progress in enhancing cooperation and coordination in respect of tuberculosis research and development, considering where possible drawing on relevant existing research networks and global initiatives;
- (5) to continue to develop, in consultation with Member States, the draft multisectoral accountability framework, working in close collaboration with all relevant international, regional and national partners as recommended in the Moscow Declaration to End TB (2017),¹ and to provide technical support to Member States and partners, as appropriate, including for national adaptation and use of the draft multisectoral accountability framework to accelerate progress to end tuberculosis, taking into account national context, laws, regulations and circumstances, in order to enable the monitoring, reporting, review and actions needed to accelerate progress to end tuberculosis, both globally and nationally, leaving no one behind, through an independent, constructive and positive approach, especially in the highest burden countries, and the independent review of progress achieved by those countries;
- (6) to present the draft multisectoral accountability framework to accelerate progress to end tuberculosis at the high-level meeting of the United Nations General Assembly in 2018 on the fight against tuberculosis;
- (7) to report to the Seventy-second World Health Assembly on the implementation of this resolution.

(Seventh plenary meeting, 26 May 2018 –
Committee A, second report)

WHA71.4 Cholera prevention and control²

The Seventy-first World Health Assembly,

Recalling resolution WHA64.15 (2011) on cholera: mechanism for control and prevention, which led to the revitalization of the Global Task Force on Cholera Control to support Member States to reduce the public health, social and economic consequences of cholera by strengthening WHO's work in this area, and improving collaboration and coordination among stakeholders;

Recognizing the report by the Director-General on WHO's work in health emergencies³ and the Global Task Force on Cholera Control's recently launched strategy, Ending Cholera: A Global Roadmap to 2030,⁴ which have highlighted that large-scale outbreaks of cholera continue to cause significant morbidity and mortality among vulnerable populations in both emergency and endemic settings; and that, with an estimated disease burden of 2.9 million cases and 95 000 deaths every year

¹ See Annex 2.

² See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

³ Document A71/6.

⁴ Ending cholera: a global roadmap to 2030 (<http://www.who.int/cholera/publications/global-roadmap.pdf?ua=1>, accessed 21 May 2018).

worldwide, the disease still affects at least 47 countries around the globe, with a potential to spread where water, sanitation and hygiene conditions are inadequate;

Acknowledging that the prevention and control of cholera require a coordinated and multisectoral approach that includes access to appropriate health care, early case management, access to safe water, sanitation, education, health literacy and improved hygiene behaviours, with adjunct use of oral cholera vaccines, strengthened surveillance and information sharing, strengthened laboratory capacity and community involvement, and action on the social determinants of health;

Acknowledging also that cholera control is both a matter of emergency response in the case of outbreaks, and a matter of development when the disease is endemic in high-risk contexts, such as in camps for refugees and internally displaced people;

Affirming that progress towards the 2030 Agenda for Sustainable Development including commitment to Goal 3 (Ensure healthy lives and promote well-being for all at all ages); Goal 6 (Ensure availability and sustainable management of water and sanitation for all); and Goal 11 (Make cities and human settlements inclusive, safe, resilient and sustainable), would reduce the prevalence and spread of cholera, along with other diarrhoeal diseases and enteric infections;

Recalling that all States Parties must comply with the International Health Regulations (2005);

Acknowledging that cholera, as a disease of epidemic potential, has to be recognized in itself and reported separately from other diarrhoeal diseases, within national surveillance systems, as not doing so hampers effective control measures,

1. URGES Member States:¹

(1) to foster the identification by governments of cholera epidemics and to elevate cholera as a State priority in affected countries through its inclusion in national policies and plans, either as a stand-alone plan, or embedded within broader diarrhoeal disease control initiatives or within national health, health security, water, sanitation and hygiene, development and Sustainable Development Goal implementation plans, where relevant, and plans of national disaster and/or emergency management agencies;

(2) to develop and implement, in affected countries, a multisectoral package of selected effective prevention and control measures, including long-term water, sanitation and hygiene services, access to appropriate health care, access to safe water, sanitation and improved hygiene behaviours, as well as infrastructure development along with associated capacity-building activities for operations, maintenance and repairs and sustainable financing models adapted to the local transmission pattern for long-term control or elimination;

(3) to ensure that national policies and plans regarding the prevention and management of cholera comprise all areas with high-risk of cholera transmission;

(4) to establish national multisectoral cholera and acute diarrhoea prevention and surveillance mechanisms in affected countries to coordinate the implementation of the control or elimination plan, ensuring representation of the different ministries, agencies, partners and communities involved in cholera control efforts;

¹ And, where applicable, regional economic integration organizations.

(5) to strengthen capacity for: preparedness in compliance with the International Health Regulations (2005), early detection and treatment, laboratory confirmation, case management and immediate and effective response to outbreaks in order to reduce the public health, social and economic impact;

(6) to strengthen surveillance and early reporting of cholera in line with the International Health Regulations (2005), and build capacity for data collection and analysis, including information on critical determinants including water and sanitation coverage;

(7) to strengthen community involvement, social mobilization in cholera prevention, early detection, household water treatment and storage, and other related water, sanitation and hygiene response activities;

(8) to support, including through international cooperation, research for better prevention and control, including research for improved vaccines and better rapid diagnostics and treatment; and to support monitoring of antimicrobial resistance;

(9) to refrain from implementing health measures that are more restrictive of international traffic and more invasive or intrusive to persons than reasonably available alternatives that would achieve the appropriate level of health protection, in line with the International Health Regulations (2005);

(10) to establish national targets, when applicable, and make financial and political commitments to cholera control with national Sustainable Development Goal implementation plans;

2. REQUESTS the Director-General:

(1) to strengthen surveillance and reporting of cholera in line with the International Health Regulations (2005) and to further reinforce advocacy, strategic leadership and coordination with partners at all levels via the Global Task Force on Cholera Control secretariat and working groups, including by providing technical support and operational guidance to countries for cholera prevention and control;

(2) to increase capacity to support countries to scale up their ability to implement and monitor multisectoral, integrated interventions for long-term cholera prevention, control and elimination; interventions for preparedness and response to cholera epidemics in accordance with the global initiative of Ending Cholera: A Global Roadmap to 2030 and aligned with national plans to encourage reporting, monitor progress and disease burden in order to inform country and global strategies; and interventions for control or elimination;

(3) to support countries, upon request, in the assessment of cholera risk factors and capacity for multisectoral engagement within existing technical resources;

(4) to continue leading the management of the oral cholera vaccine stockpile to enable a sufficient global supply, including the support to and monitoring and evaluation of oral cholera vaccine use, and where appropriate vaccine campaigns, in cooperation with relevant organizations and partners, including UNICEF and Gavi, the Vaccine Alliance;

(5) to monitor and support long-term cholera prevention and control and elimination programmes at country and regional levels;

(6) to develop and promote an outcome-oriented research and evaluation agenda for cholera, targeted to address important knowledge gaps, to the improvement of implementation of existing interventions, including for water sanitation and hygiene, and to the development of improved vaccines for better and more durable prevention and outbreak control covering all aspects of cholera control;

(7) to raise the profile of cholera at the highest levels on the global public health agenda, and to strengthen coordination and engagement of multiple sectors, particularly water, sanitation and hygiene, and other non-health sectors such as finance and infrastructure development;

(8) to report to the Seventy-third World Health Assembly, through the Executive Board at its 146th session, on the global cholera situation and evaluate efforts made in cholera prevention and control.

(Seventh plenary meeting, 26 May 2018 –
Committee A, second report)

WHA71.5 Addressing the burden of snakebite envenoming¹

The Seventy-first World Health Assembly,

Having considered the report on global snakebite burden;²

Deeply concerned that snakebite envenoming³ kills an estimated 81 000–138 000 men, women and children a year worldwide and causes physical and psychological disability in four or five times that figure;

Noting that the individuals affected by snakebite are overwhelmingly members of impoverished agricultural and herding communities, the great proportion of whom are 10–40 years of age;

Concerned that several factors, including poor prevention, health worker training, diagnosis and treatment of cases of snakebite envenoming and inadequacy of available tools for prevention, diagnosis and treatment of the disease, impede further progress in addressing snakebite envenoming;

Recognizing that snakebite envenoming causes disproportionate suffering, but has to date been largely overlooked by the global health community even though it can induce catastrophic health expenditure and exacerbate poverty;

Recognizing further that snakebite envenoming has been categorized by WHO as a high priority neglected tropical disease,⁴ following the recommendation of WHO's Strategic and Technical Advisory Group for Neglected Tropical Diseases at its 10th meeting (Geneva, 29 and

¹ See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

² Document A71/17.

³ Snakebite envenoming is the disease resulting from the pathological and pathophysiological alterations induced by the deleterious action of venom injected in the body as a consequence of snakebite.

⁴ See <http://www.who.int/snakebites/resources/s40409-017-0127-6/en/> (accessed 8 December 2017).

30 March 2017),¹ in response to the urgent need to implement effective control strategies, tools and interventions;

Recognizing also the lack of statistics and accurate information and the need to further improve data on the epidemiology of snakebite envenoming for a better understanding of the disease and its control;

Aware that early diagnosis and treatment are essential for reducing the morbidity, disability and mortality that snakebite envenoming can cause;

Noting with satisfaction the progress made by some Member States with regard to research into snakebite envenoming and improved case management;

Acknowledging the urgent need to improve access to safe, effective and affordable treatments in all regions of the world where snakebite envenoming is endemic;

Recognizing the work of WHO towards developing guidelines for the diagnosis and management of snakebite envenoming and for the production, control and regulation of antivenoms, and the need to make these available to all regions of the world;

Mindful that achievement of the Sustainable Development Goals of the 2030 Agenda for Sustainable Development, particularly those concerning poverty, hunger, health and education, may be hampered by the negative impact of neglected diseases of the poor, including snakebite envenoming,

1. URGES Member States:²

- (1) to assess the burden of snakebite envenoming and, where necessary, establish and/or strengthen surveillance, prevention, treatment and rehabilitation programmes;
- (2) to improve the availability, accessibility and affordability of antivenoms to populations at risk, and develop mechanisms to ensure that additional costs related to treatment and rehabilitation after snakebite envenoming are affordable for all;
- (3) to promote the transfer of knowledge and technology between Member States in order to improve the global availability of antivenoms and the effective management of cases;
- (4) to integrate, where possible and appropriate, efforts to control snakebite envenoming with other relevant disease-control activities;
- (5) to improve access to specific treatment and rehabilitation services for the individuals affected by snakebite envenoming, by mobilizing national resources;
- (6) to provide training to relevant health workers on the diagnosis and management of snakebite envenoming, with particular emphasis in regions of high incidence;
- (7) to intensify and support research on snakebite envenoming, particularly in order to develop new tools to diagnose, treat, prevent and measure the burden of the disease;

¹ See http://www.who.int/neglected_diseases/NTD_STAG_report_2017.pdf?ua=1 (accessed 24 May 2018).

² And, where applicable, regional economic integration organizations.

(8) to promote community awareness of snakebite envenoming, through culturally contextualized public campaigns, in support of early treatment and prevention, and intensify community participation in awareness and prevention efforts;

(9) to foster cooperation and collaboration among Member States, the international community and relevant stakeholders in order to strengthen national capacities to control, prevent and treat snakebite envenoming;

2. REQUESTS the Director-General:

(1) to accelerate global efforts for, and provide coordination in, the control of snakebite envenoming, ensuring the quality and safety of antivenoms and other treatments and prioritization of high-impact interventions;

(2) to continue to offer technical support to institutions working on research into snakebite envenoming, including WHO collaborating centres, in support of improved, evidence-based disease control efforts;

(3) to foster international efforts aimed at improving the availability, accessibility and affordability of safe and effective antivenoms for all;

(4) to provide support to Member States for strengthening their capacities to improve awareness, prevention and access to treatment and reduce and control snakebite envenoming;

(5) to foster technical cooperation among Member States as a means of strengthening surveillance, treatment and rehabilitation services;

(6) to cooperate, as appropriate and in accordance with their respective mandates, with international agencies, nongovernmental organizations, foundations and research institutions, directly to provide support to Member States in which snakebite envenoming is prevalent, upon request, in order to strengthen snakebite management activities;

(7) to report on progress in implementing this resolution to the Seventy-third World Health Assembly.

(Seventh plenary meeting, 26 May 2018 –
Committee A, second report)

WHA71.6 WHO's global action plan on physical activity 2018–2030¹

The Seventy-first World Health Assembly,

Having considered the report on physical activity for health;²

Concerned by the rapidly growing burden of noncommunicable diseases, mental health disorders and other mental health conditions globally, and its negative impact on health, well-being, quality of life, and socioeconomic development;

¹ See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

² Document A71/18.

Acknowledging that increasing physical activity and reducing sedentary behaviour can prevent at least 3.2 million noncommunicable disease-related mortalities globally per year,¹ reduce related disability and morbidity and the financial burden on health systems, and increase the number of healthy life years;

Recalling the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (2011),² the outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases (2014),³ the 2030 Agenda for Sustainable Development,⁴ Health Assembly resolutions WHA51.18 (1998) and WHA53.17 (2000) on the prevention and control of noncommunicable diseases, WHA55.23 (2002) on diet, physical activity and health, WHA57.17 (2004) on the global strategy on diet, physical activity and health, and WHA66.10 (2013) on follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, which endorsed the global action plan for the prevention and control of noncommunicable diseases 2013–2020, and which adopted a voluntary global target to, by 2025, achieve a 10% relative reduction in prevalence of insufficient physical activity;

Acknowledging the Secretariat's work in providing Member States with tools, including WHO's global Noncommunicable Diseases Progress Monitor, and guidelines to promote physical activity,⁵ and further acknowledging that supplementary tools and guidelines may need to be developed to support Member States to scale up their actions in increasing physical activity and reducing sedentary behaviour;

Recognizing the efforts made by Member States and all relevant stakeholders in recent years to promote physical activity and reduce sedentary behaviour as part of broader efforts to prevent and control noncommunicable diseases and improve mental health;

Recognizing also the need to further scale up actions and enable environments to facilitate physical activity and reduce sedentary behaviour throughout the life course, bearing in mind different national contexts, priorities and policy opportunities,

1. ENDORSES the global action plan on physical activity 2018–2030;⁶
2. ADOPTS the voluntary global target of a 15% relative reduction, using a baseline of 2016, in the global prevalence of physical inactivity in adolescents⁷ and in adults⁸ by 2030, as an extension of

¹ Global Status Report on Noncommunicable Diseases 2014. Geneva: World Health Organization; 2014, page 33.

² United Nations General Assembly resolution 66/2 (2011).

³ General Assembly resolution 68/300 (2014).

⁴ General Assembly resolution 70/1 (2015).

⁵ Global recommendations on physical activity for health. Geneva: World Health Organization; 2010 (<http://www.who.int/dietphysicalactivity/publications/9789241599979/en/>, accessed 22 January 2018).

⁶ See Annex 3.

⁷ Insufficient physical activity among adolescents (aged 11–17 years) is defined as less than 60 minutes of moderate to vigorous intensity activity daily.

⁸ Insufficient physical activity among adults (aged 18+ years) is defined as less than 150 minutes of moderate-intensity activity per week.

the existing voluntary global target of a 10% relative reduction in prevalence of insufficient physical activity by 2025;¹

3. URGES Member States² to implement the global action plan on physical activity 2018–2030, according to national contexts and priorities, and to monitor and report on progress regularly in order to improve programme performance;

4. INVITES relevant national, regional and international partners along with other relevant stakeholders, including the private sector, to implement the global action plan on physical activity 2018–2030 and contribute to the achievement of its strategic objectives, aligned with domestic plans or strategies;

5. REQUESTS the Director-General:

(1) to implement the actions for the Secretariat in the global action plan on physical activity 2018–2030, including providing the necessary support to Member States for implementation of the plan, in collaboration with other relevant partners;

(2) to finalize, in consultation with Member States and other relevant stakeholders, a monitoring and evaluation framework on the implementation of the global action plan on physical activity 2018–2030, including a recommended set of process and impact indicators, by the end of 2018, taking into account the existing monitoring framework and indicators at the global and regional levels, and to publish it on the WHO website;

(3) to produce, before the end of 2020, the first global status report on physical activity, building on the latest available evidence and international experience, including on sedentary behaviour;

(4) to incorporate reporting on progress made in implementing the global action plan on physical activity 2018–2030 in the reports to be submitted to the Health Assembly in 2021 and 2026 in accordance with the agreed reporting sequence set out in resolution WHA66.10 (2013); and to submit a final report on the global action plan on physical activity 2018–2030 to the Health Assembly in 2030;

(5) to update the global recommendations on physical activity for health 2010.

(Seventh plenary meeting, 26 May 2018 –
Committee A, second report)

WHA71.7 Digital health³

The Seventy-first World Health Assembly,

Having considered the report on mHealth;⁴

¹ See resolution WHA66.10.

² And, where applicable, regional economic integration organizations.

³ See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

⁴ Document A71/20.

Recalling resolutions WHA58.28 (2005) on eHealth and WHA66.24 (2013) on eHealth standardization and interoperability;

Recognizing the potential of digital technologies to advance the Sustainable Development Goals, in particular by supporting health systems in all countries in health promotion and disease prevention, and by improving the accessibility, quality and affordability of health services;

Recognizing also that while technology and innovations can enhance health service capabilities, human interaction remains a key element to patients' well-being;

Underscoring the need to ensure that digital health solutions complement and enhance existing health service delivery models, strengthen integrated, people-centred health services and contribute to improved population health, and health equity, including gender equality, and address the lack of evidence on the impact of digital health in these respects;

Acknowledging that the transfer of technology and knowledge on mutually agreed terms, as well as technical cooperation, aligned with Sustainable Development Goal 17 (Strengthen the means of implementation and revitalize the global partnership for sustainable development), are important in promoting digital health;

Highlighting recent progress in the development and implementation of digital health strategies, policies, legislation and programmes by Member States,¹ WHO and partner organizations;

Acknowledging the previous experience² of countries and organizations, the interconnectedness of digital technologies, the collection, management and evaluation of health data, the robustness of the enabling environment, in line with established good practices, while considering the sustainability of innovations, and their feasibility, scale-up and inclusivity,

1. URGES Member States:¹

(1) to assess their use of digital technologies for health, including in health information systems at the national and subnational levels, in order to identify areas of improvement, and to prioritize, as appropriate, the development, evaluation, implementation, scale-up and greater utilization of digital technologies, as a means of promoting equitable, affordable and universal access to health for all, including the special needs of groups that are vulnerable in the context of digital health;

(2) to consider, as appropriate, how digital technologies could be integrated into existing health systems' infrastructures and regulation, to reinforce national and global health priorities by optimizing existing platforms and services, for the promotion of people-centred health and disease prevention and in order to reduce the burden on health systems;

(3) to optimize, in health systems development and reforms, the use of resources by developing health services alongside the application and use of digital technologies;

¹ And, where applicable, regional economic integration organizations.

² Programmes specified in comments from Missions included the Global Observatory for eHealth, WHO-ITU initiative on mHealth for noncommunicable diseases, the Innovation Working Group, Every Woman Every Child initiative and the WHO-ITU National eHealth Strategy Toolkit. Principles for Digital Development (WHO endorsed).

(4) to identify priority areas where normative guidance and technical assistance and advice on digital health would be beneficial, including, but not limited to, gaps in research, evidence-based standards, support to implementation and scale-up, financing and business models, content, evaluation, cost-effectiveness and sustainability, data security, ethical and legal issues, re-use and adaptation of existing digital health and other relevant tools;

(5) to work towards and support interoperability of digital technologies for health by, inter alia, promoting the use of international and open standards as an affordable, effective and easily adaptable solution;

(6) to disseminate, as appropriate, best practices and successful examples of digital health architecture, programmes, and services, in particular effective policy design and practical implementation, with the international community, including through WHO, bilateral, regional, cross-regional and global networks, digital platforms and hubs;

(7) to strengthen public health resilience and promote opportunities, as appropriate, including to improve access to, and monitoring, sharing and use of, quality data, direct citizen, health worker and government engagement, and to build capacity for rapid response to disease incidents and public health emergencies, leveraging the potential of digital information and communication technologies to enable multidirectional communications, feedback loops and data-driven “adaptive management”;

(8) to build, especially through digital means, capacity for human resources for digital health, as appropriate, across both the health and technology sectors, and to communicate areas of specific need to WHO in order to receive appropriate technical assistance;

(9) to improve the digital skills of all citizens, including through working with civil society to build public trust and support for digital health solutions, and to promote the application of digital health technology in the provision of, and access to, everyday health services;

(10) to develop, as appropriate, legislation and/or data protection policies around issues such as data access, sharing, consent, security, privacy, interoperability and inclusivity consistent with international human rights obligations, and to communicate these on a voluntary basis to WHO;

(11) to develop, as appropriate, and in coordination with existing and emerging regional hubs and support mechanisms, effective partnerships with stakeholders from across all sectors in the use of digital health;

2. REQUESTS the Director-General:

(1) to develop, within existing resources, and in close consultation with Member States¹ and with inputs from relevant stakeholders as appropriate, a global strategy on digital health, identifying priority areas including where WHO should focus its efforts;

(2) to elevate the strategic capacity of WHO in digital technologies and to mainstream these in WHO’s work, operations and relevant programmes, including when working with Member States;

¹ And, as applicable, regional economic integration organizations.

- (3) to provide technical assistance and normative guidance to Member States, on request, for scaling up the implementation of digital health – including through the development and implementation of Member States’ digital health strategies, and in line with the Thirteenth General Programme of Work, 2019–2023, with the appropriate structure, resources, assets and capabilities, within existing resources;
- (4) to ensure that WHO builds on its strengths, by developing guidance for digital health, including, but not limited to, health data protection and usage, on the basis of its existing guidelines and successful examples from global, regional and national programmes, including through the identification and promotion of best practices, such as evidence-based digital health interventions and standards;
- (5) to develop a repository on regulations, evidence related to improvements and unintended effects regarding health promotion, disease prevention and access to, and quality and cost-effectiveness of, health services, and best practices relating to digital health technologies, provided by, inter alia, Member States on a voluntary basis;
- (6) to monitor developments and trends of digital technologies in health systems, public health and data science, and analyse their implications for the achievement of the health-related Sustainable Development Goals;
- (7) to promote WHO’s collaboration with other organizations of the United Nations system and other relevant stakeholders to strengthen digital health implementation, by leveraging their capabilities;
- (8) to submit a report to the Seventy-third World Health Assembly in 2020 on the progress made in implementing this resolution.

(Seventh plenary meeting, 26 May 2018 –
Committee A, third report)

WHA71.8 Improving access to assistive technology¹

The Seventy-first World Health Assembly,

Having considered the report on improving access to assistive technology;²

Considering that one billion people need assistive technology and that, as the global population ages and the prevalence of noncommunicable diseases increases, this figure will rise to more than two billion by 2050;³

Noting that assistive technology enables and promotes the inclusion, participation and engagement of persons with disabilities, ageing populations and people with co-morbidities in the family, community and all areas of society, including the political, economic and social spheres;

¹ See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

² Document A71/21.

³ World Health Organization, World Bank. World report on disability. Geneva: World Health Organization; 2011.

Recalling that 90% of those who need assistive technology do not have access to it, and that this has a significant adverse impact on the education, livelihood, health and well-being of individuals, and on families, communities and societies;¹

Recalling also the 2030 Agenda for Sustainable Development and its ultimate aim of ensuring that “no one is left behind”;

Recognizing that the inclusion of assistive technology, in line with countries’ national priorities and context, into health systems is essential for realizing progress towards the targets in the Sustainable Development Goals relating to universal health coverage, inclusive and equitable quality education, inclusive and sustainable economic growth, full and productive employment and decent work for all, reducing inequality within and among countries by empowering and promoting the social, economic and political inclusion of all, making cities and human settlements inclusive, safe and sustainable, and providing universal access to safe, inclusive and accessible green and public spaces, particularly for persons with disabilities;

Recalling the United Nations Convention on the Rights of Persons with Disabilities, under which 175 Member States have committed, inter alia, to ensuring access to quality assistive technology at an affordable cost (Articles 4, 20, and 26) and to foster international cooperation (Article 32) in support of national efforts for the realization of the purpose and objectives of the Convention;

Emphasizing the need for a comprehensive, sustainable and multisectoral approach to improving access to assistive technology that fulfils the safety and quality standards established by national and international regulations, at the national and subnational levels;

Recalling resolutions WHA69.3 (2016), WHA67.7 (2014), and WHA66.4 (2013) and WHA70.13 (2017) in which, respectively, the Health Assembly calls on Member States, inter alia, to improve access to assistive technology for older people, people with disabilities and people with vision and hearing loss;

Noting the request made to the Executive Board by the WHO Regional Committee for the Eastern Mediterranean, in resolution EM/RC63/R.3 (2016) on improving access to assistive technology, to include assistive technology as an agenda item for the Health Assembly,

1. URGES Members States:²

- (1) to develop, implement and strengthen policies and programmes, as appropriate, to improve access to assistive technology within universal health and/or social services coverage;
- (2) to ensure that adequate and trained human resources for the provision and maintenance of assistive products are available at all levels of health and social service delivery;
- (3) to ensure that assistive technology users and their carers have access to the most appropriate assistive products and use them safely and effectively;

¹ Document A71/21.

² And, where applicable, regional economic integration organizations.

(4) where appropriate, based on national needs and context, to develop a national list of priority assistive products that are affordable and cost-effective and that meet minimum quality and safety standards, drawing on WHO's priority assistive products list;

(5) to promote or invest in research, development, innovation and product design in order to make existing assistive products affordable; and to develop a new generation of products including high-end or advanced assistive technology, taking advantage of universal design and new evidence-based technologies, in partnership with academia, civil society organizations, in particular with persons with disabilities and older persons and their representative organizations, and the private sector, as appropriate;

(6) to encourage international and/or regional collaboration for the manufacturing, procurement and supply of priority assistive products, ensuring that these remain affordable and available across borders;

(7) to collect population-based data on health and long-term care needs, including those that may be met by assistive technology in order to develop evidence-based strategies, policies and comprehensive programmes;

(8) to invest in and promote inclusive barrier-free environments so that all people who need assistive technology can make optimum use of it, in order to live independently and safely and participate fully in all aspects of life;

(9) to promote the inclusion of priority assistive products and inclusive barrier-free environments within emergency preparedness and response programmes;

2. REQUESTS the Director-General:

(1) by 2021, to prepare a global report on effective access to assistive technology in the context of an integrated approach, based on the best available scientific evidence and international experience, with the participation of all relevant units within the Secretariat and in collaboration with all relevant stakeholders, giving consideration to the possibility of establishing an Expert Advisory Group, within existing resources, for this purpose;

(2) to provide the necessary technical and capacity-building support for Member States, aligned with national priorities, in the development of national assistive technology policies and programmes, including procurement and financing, regulation, training for health and social services, appropriate service delivery, and inclusive barrier-free environments;

(3) to provide technical and capacity-building support to countries, on request, to assess the feasibility of establishing regional or subregional manufacturing, procurement and supply networks for assistive technology and cooperation platforms;

(4) to contribute to and engage in, as appropriate, the development of minimum standards for priority assistive products and services, in order to promote their safety, quality, cost-effectiveness and appropriateness;

(5) to report on progress in the implementation of the present resolution to the Seventy-fifth World Health Assembly and thereafter to submit a report to the Health Assembly every four years until 2030.

WHA71.9 Infant and young child feeding¹

The Seventy-first World Health Assembly,

Having considered the reports on maternal, infant and young child nutrition;²

Recalling resolutions WHA33.32 (1980), WHA34.22 (1981), WHA35.26 (1982), WHA37.30 (1984), WHA39.28 (1986), WHA41.11 (1988), WHA43.3 (1990), WHA45.34 (1992), WHA46.7 (1993), WHA47.5 (1994), WHA49.15 (1996), WHA54.2 (2001), WHA55.25 (2002), WHA58.32 (2005), WHA59.21 (2006), WHA61.20 (2008), WHA63.23 (2010), WHA65.6 (2012) and WHA69.9 (2016) on infant and young child nutrition, appropriate feeding practices and related questions, as well as resolutions WHA68.19 (2015), WHA69.8 (2016) and United Nations General Assembly resolution 70/1 (2015);

Reaffirming the commitment made in the 2030 Agenda for Sustainable Development, including to end all forms of malnutrition by 2030;

Recalling the commitment to implement relevant international targets and action plans, including WHO's global maternal, infant and young child nutrition targets for 2025 and WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2020 and the Rome Declaration on Nutrition resulting from the Second International Conference on Nutrition;

Reaffirming also that breastfeeding is critical for child survival, nutrition and development, and for maternal health;

Affirming that the protection, promotion and support of breastfeeding contributes substantially to the achievement of the Sustainable Development Goals on nutrition and health, and is a core element of quality health care;

Recognizing that appropriate, evidence-based and timely support of infant and young child feeding in emergencies saves lives, protects child nutrition, health and development, and benefits mothers and families;

Expressing concern that nearly two in every three infants under 6 months of age are not exclusively breastfed; that fewer than one in five infants are breastfed for 12 months in high-income countries; and that only two in every three children between 6 months and 2 years of age receive any breast milk in low- and middle-income countries;

Acknowledging that achievement of the WHO global target to increase to at least 50% the proportion of infants under 6 months of age who are exclusively breastfed by 2025 requires sustainable and adequate technical and financial resources, and supportive and protective policy and regulatory interventions, as well as political will, and that this needs to be part of broader efforts to strengthen health systems;

Welcoming the inclusion of support for exclusive breastfeeding in the Thirteenth General Programme of Work, 2019–2023;

¹ See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

² Documents A71/22 and A71/23.

Welcoming also the annual celebration of World Breastfeeding Week as an opportunity to communicate the importance of breastfeeding and advocate for the protection, promotion and support of breastfeeding;¹

Also recognizing the ongoing implementation by WHO of the Framework of Engagement with Non-State Actors, including in nutrition programmes,

1. URGES Member States^{2,3,4} in accordance with national context and international obligations:

(1) to increase investment in development, implementation and monitoring and evaluation of laws, policies and programmes aimed at protection, promotion, including education and support of breastfeeding, including through multisectoral approaches and awareness raising;

(2) to reinvigorate the Baby-friendly Hospital Initiative, including by promoting full integration of the revised Ten Steps to Successful Breastfeeding, in efforts and programmes aimed at improving quality of care in support of maternal, newborn and child health;

(3) to implement and/or strengthen national mechanisms for effective implementation of measures aimed at giving effect to the International Code of Marketing of Breast-milk Substitutes, as well as other WHO evidence-based recommendations;

(4) to promote timely and adequate complementary feeding in accordance with the guiding principles for complementary feeding of the breastfed child,⁵ as well as guiding principles for feeding non-breastfed children 6–24 months of age;⁶

(5) to continue taking all necessary measures in the interest of public health to implement recommendations to end inappropriate promotion of foods for infants and young children;

(6) to take all necessary measures to ensure evidence-based and appropriate infant and young child feeding during emergencies, including through preparedness plans, capacity-building of personnel working in emergency situations, and coordination of intersectoral operations;

(7) to celebrate World Breastfeeding Week⁷ as a valuable means to promote breastfeeding;

2. REQUESTS the Director-General:

(1) to provide, upon request, technical support to Member States in mobilizing resources, including financial resources, and monitoring and implementation of WHO recommendations to support infant and young child feeding, including in emergencies, and to review national

¹ <http://worldbreastfeedingweek.org/>, accessed 21 May 2018.

² And where applicable, regional economic integration organizations.

³ Taking into account the context of federated states.

⁴ Member States could take additional action to end inappropriate promotion of food for infants and young children.

⁵ Guiding principles for complementary feeding of the breastfed child. Washington (DC): PAHO; 2003 (http://www.who.int/maternal_child_adolescent/documents/a85622/en/, accessed 21 May 2018).

⁶ Guiding principles for feeding non-breastfed children 6-24 months of age. Geneva: World Health Organization; 2005 (http://www.who.int/maternal_child_adolescent/documents/9241593431/en/, accessed 18 May 2018).

⁷ <http://worldbreastfeedingweek.org/>, accessed 21 May 2018.

experiences arising from this implementation and continue to update and generate evidence-based recommendations;

(2) to provide, upon request, technical support to Member States to establish, review and implement national laws, policies and programmes to support infant and young child feeding;

(3) to continue developing tools for training, monitoring and advocacy on the revised Ten Steps to Successful Breastfeeding and the Baby-friendly Hospital Initiative, in order to provide support to Member States with implementation;

(4) to support Member States in establishing nutrition targets and intermediate milestones for maternal, infant and young child nutrition indicators, consistent with the time frame for implementation of the Framework for Action, the conference outcome document of FAO and WHO's Second International Conference on Nutrition, and the United Nations Decade of Action on Nutrition (2016–2025) and the timeframe of the Sustainable Development Goals (2015–2030);

(5) to continue providing adequate technical support to Member States, upon request, in assessing national policies and programmes, and other measures, including quality data collection and analyses;

(6) to develop tools for training, monitoring, advocacy and preparedness for the implementation of the operational guidance on infant and young child feeding in emergencies, and support Member States in reviewing experiences in its adaptation, implementation and monitoring;

(7) to report to the Seventy-third World Health Assembly in 2020 on the progress made in implementing this resolution and in alignment with the reporting requested in resolution WHA69.9.

(Seventh plenary meeting, 26 May 2018 –
Committee A, fourth report)

WHA71.10 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-first World Health Assembly,

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

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

¹ Document A71/31 Rev.1.

² Document A71/47.

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

Noting that Cameroon, Libya, Niger and Venezuela (Bolivarian Republic of) were in arrears at the time of the opening of the Seventy-first 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-second World Health Assembly in 2019,

DECIDES:

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

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

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

(Seventh plenary meeting, 26 May 2018 –
Committee B, second report)

WHA71.11 Deputy Directors-General¹

The Seventy-first World Health Assembly,

Noting the recommendations of the Executive Board with regard to Articles I, III and IV of the Staff Regulations,²

1. ADOPTS the proposed amendments to Staff Regulations 1.11, 3.1 and 4.5;³
2. DECIDES that these amendments shall take effect from 1 January 2018.

(Seventh plenary meeting, 26 May 2018 –
Committee B, second report)

¹ See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

² Document A71/37.

³ See Annex 4.

WHA71.12 Salaries of staff in ungraded positions and of the Director-General¹

The Seventy-first World Health Assembly,

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

1. ESTABLISHES the salaries of Assistant Directors-General and Regional Directors at US\$ 176 292 gross per annum, with a corresponding net salary of US\$ 131 853;
2. ESTABLISHES the salary of Deputy Directors-General at US\$ 194 329 gross per annum, with a corresponding net salary of US\$ 143 757;
3. ESTABLISHES the salary of the Director-General at US\$ 239 755 gross per annum, with a corresponding net salary of US\$ 173 738;
4. DECIDES that those adjustments in remuneration shall take effect on 1 January 2018.

(Seventh plenary meeting, 26 May 2018 –
Committee B, second report)

WHA71.13 Reform of the global internship programme¹

The Seventy-first World Health Assembly,

Having considered the human resources annual reports of 2015, 2016 and 2017;³

Recognizing, consistent with the implementation of the 2030 Agenda for Sustainable Development and progress towards the attainment of universal health coverage, the need for effective public health leadership, resilient health systems and strong health workforce capacity;

Guided by the Thirteenth General Programme of Work, outlining the WHO's strategic vision for the period 2019–2023, which commits to, inter alia, promoting greater access to, and equity in, the internship programme;

Affirming the internship programme's goal to build future leaders in public health through professional training and capacity-building opportunities across headquarters, regional and country offices, and the valuable contributions interns make to the Organization;⁴

Recalling Member States' concerns over the persistent imbalance in geographical participation in the internship programme, due in large part to the absence of financial support for talented future

¹ See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

² See document A71/37.

³ Documents A69/52, A70/45 and A71/35.

⁴ The WHO e-Manual defines an intern as an individual who is at least 20 years old, enrolled in a university or equivalent institution leading to a formal qualification (graduate or postgraduate). Applicants who have already graduated may also qualify for consideration provided that they apply for an internship within six months after completion of their formal qualification. Interns do not have the status of WHO staff members and cannot represent the Organization in any official capacity.

health leaders and insufficient attention paid so far to geographical diversity and gender equity among interns;

Underscoring the commitment of all Member States towards improvements in the WHO reform process across the three levels of the Organization, including balanced geographical participation and gender equity;

Recognizing WHO's efforts and changes to improve the transparency and accessibility of the internship programme and its ambition to implement comprehensive reform,

1. DECIDES that continued improvements to the internship programme shall be achieved through:

(1) the development of a sustainable and equitable internship programme based on an internship strategy and semi-structured training curriculum for interns to maximize their training experience and reinforce the learning objectives of the programme, which are, inter alia, to build a diverse pool of future leaders in public health and provide experience in the technical and administrative programmes of WHO;

(2) the strengthening of a transparent, merit-based intern recruitment process that promotes the widest possible geographical participation and gender equity, through objective review of all intern applicants who meet the criteria;

(3) the setting of a target that by 2022, at least 50% of accepted interns on the programme originate from least developed countries and middle-income countries with the objective of achieving balanced participation among WHO regions and gender equity;

(4) the provision by the Secretariat of financial assistance, as soon as possible and no later than 2020, and where applicable, in-kind assistance, including through collaboration with host countries, for all accepted interns without sufficient existing support, at a level set for the duty station, to cover reasonably incurred travel and living expenses for the duration of the internship;

2. URGES Member States, development partners and donors to support WHO in mobilizing the resources necessary for financial sustainability and where applicable in-kind assistance for the internship programme, thereby ensuring that talented future health leaders from all Member States can equally access the programme, irrespective of economic circumstance;

3. INVITES international, regional, national and local stakeholders to engage in and support the implementation of the actions set out in this resolution;

4. REQUESTS the Director-General:

(1) to take the necessary measures and, in keeping with the aims of broader human resources policy, to operationalize the objectives of this resolution, across all three levels of the Organization, drawing from the best practices of other United Nations organizations and in line with United Nations rules, regulations and relevant resolutions;

(2) to include as part of the human resources annual report, statistics on applicants' and accepted interns' demographic data, including gender and country of origin, as well as information on progress towards the implementation of this resolution;

(3) to submit a report to the Executive Board at its 144th session in January 2019, detailing by which mechanism financial and in-kind support to accepted interns will be provided commensurate with their needs;

(4) to submit a stand-alone report to the Seventy-sixth World Health Assembly through the Executive Board in 2023, outlining the progress made in achieving the targets set out in this resolution and the future steps planned.

(Seventh plenary meeting, 26 May 2018 –
Committee B, second report)

WHA71.14 Rheumatic fever and rheumatic heart disease¹

The Seventy-first World Health Assembly,

Having considered the report on rheumatic fever and rheumatic heart disease;²

Reaffirming resolutions: WHA66.10 (2013) on follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases; WHA68.7 (2015) on global action plan on antimicrobial resistance; WHA69.2 (2016) on committing to implementation of the Global Strategy for Women's, Children's and Adolescents' Health; and WHA69.25 (2016) on addressing the global shortage of medicines and vaccines, and the safety and efficacy of children's medicine; and the 2015 African Union Addis Ababa Communiqué on Eradication of Rheumatic Heart Disease in Africa;³

Noting with concern that rheumatic heart disease is a significant, preventable cause of morbidity and mortality for people in all WHO regions which, even with incomplete data, is known to affect at least 33 million individuals and cause over 300 000 deaths annually, especially among vulnerable and marginalized groups including children, adolescents, pregnant women and poor and indigenous populations;⁴

Recognizing that rheumatic heart disease is a preventable condition arising from acute rheumatic fever, a secondary sequela of group A beta haemolytic streptococcal pharyngitis, and that early detection and diagnosis of this form of pharyngitis, acute rheumatic fever and rheumatic heart disease, with judicious antibiotic treatment of group A beta haemolytic streptococcal pharyngitis and appropriate antibiotic prophylaxis for those who have experienced acute rheumatic fever, can substantially reduce morbidity and mortality in a cost-effective way;

Concerned by a lack of reliable access to essential medicines for the prevention and treatment of group A beta haemolytic streptococcal pharyngitis, acute rheumatic fever and rheumatic heart disease;

Recalling that global initiatives can provide much-needed leadership, awareness and momentum to "beat" rheumatic heart disease, as demonstrated by the WHO global programme for the prevention and control of rheumatic heart disease (1984–2002);

¹ See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

² Document A71/25.

³ Available at http://www.pascal.org/uploads/files/ADDIS_ABABA_COMMUNIQU%C3%89_ON_ERADICATION_OF_RHUEMATIC_HEART_DISEASE_IN_AFRICA_-_Submission1.pdf, accessed 30 May 2017.

⁴ The Global Burden of Disease Study 2010.

Recognizing that rheumatic heart disease is a preventable disease of poverty, that pursuit of the Sustainable Development Goals to end poverty and achieve universal health coverage is therefore critical, and that reducing barriers to effective prevention and control is consistent with the WHO Constitution and priority work areas,

1. URGES Member States:¹

(1) to accelerate multisectoral efforts towards reducing poverty and improving socioeconomic standards by all means, tackling the known root determinants of rheumatic heart disease, including poor housing, overcrowding and reduced access to care;

(2) to estimate the burden of rheumatic heart disease, and, in the case of countries where the disease is endemic, in accordance with their national context and priorities, to implement and resource rheumatic heart disease programmes that foster multisectoral work focused on prevention, improved disease surveillance and collection and analysis of good-quality data that facilitate appropriate follow-up and contribute to a broader understanding of the global disease burden;

(3) to improve access to primary health care, including through investing in a community and primary health care workforce trained in prevention, diagnosis and evidence-based management of group A beta haemolytic streptococcal pharyngitis, acute rheumatic fever and rheumatic heart disease with its potential complications, alongside improving understanding of prevention and control of rheumatic heart disease among at-risk populations;

(4) to ensure timely, affordable and reliable access to cost-effective essential laboratory technologies and medicines for the diagnosis, prevention and treatment of acute rheumatic fever and rheumatic heart disease;

(5) to strengthen national and international cooperation to address rheumatic heart disease, including through setting global and national measures for reducing the burden of disease, utilizing and sharing best practice methodologies for prevention and control, and creating national and regional networks for specialist diagnosis and treatment, when needed;

2. INVITES relevant international stakeholders such as nongovernmental organizations, academic institutions, private sector entities and philanthropic foundations, as appropriate, to assist in driving forward global efforts for the prevention and control of rheumatic heart disease, and collaborate:

(1) to put people living with rheumatic heart disease at the centre of the prevention and control agenda, and to continue to advocate on behalf of communities at risk of, or affected by, rheumatic heart disease;

(2) to raise the profile of rheumatic heart disease and other noncommunicable diseases of children and adolescents on the global agenda, with a view to strengthening health systems in low- and middle-income countries, eradicating poverty and addressing health inequities;

(3) to facilitate timely, affordable and reliable access to existing and cost-effective new medicines and technologies for prevention and control of rheumatic heart disease by supporting research and development, including gaining a greater understanding of the pathogenesis and

¹ And, where applicable, regional economic integration organizations.

epidemiology of acute rheumatic fever and rheumatic heart disease, and by providing open-access resources;

3. REQUESTS the Director-General:

(1) to reinvigorate engagement in, and lead and coordinate global efforts on, prevention and control of rheumatic heart disease, ensuring adequate resourcing, with rheumatic heart disease considered broadly across relevant WHO work areas, extending beyond the noncommunicable disease programme;

(2) to support Member States in identifying rheumatic heart disease burden and, where appropriate, in developing and implementing rheumatic heart disease programmes and strengthening health systems in order to improve disease surveillance, increase the availability and training of the community and primary health care workforce, and ensure reliable access to affordable prevention, diagnostic and treatment tools;

(3) to foster international partnerships for mobilizing resources, sharing best practice methodologies, developing and supporting a strategic research and development agenda, and facilitating access to existing and new medicines and technologies;

(4) to assess and report on the magnitude and nature of the problem of rheumatic heart disease according to agreed measures, and to monitor efforts for the prevention and control of rheumatic heart disease;

(5) to report on implementation of this resolution to the Seventy-fourth World Health Assembly.

(Seventh plenary meeting, 26 May 2018 –
Committee B, third report)

WHA71.15 Multilingualism: respect for equality among the official languages¹

The Seventy-first World Health Assembly,

Having considered the report by the Director-General;²

Recalling United Nations General Assembly resolution 71/328, which calls for multilingualism to be addressed in a cost-neutral practical, efficient and cost-effective manner;

Mindful that the universality of WHO is based, inter alia, on multilingualism and on respect for the parity and plurality of the official languages chosen by the Member States;

Recalling the resolutions and rules governing language arrangements at WHO, especially resolution WHA50.32 (1997) on respect for equality among the official languages, resolution WHA51.30 (1998) on method of work of the Health Assembly, which requested the Director-General to make WHO governing body documents available on the internet, and resolution EB105.R6 (2000) on the use of languages in WHO;

¹ See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

² Document A71/50.

Convinced of the importance of respect for the diversity of cultures and the plurality of international languages for improving health policies in the world, especially in the developing countries, and for giving all Member States access to information and to scientific and technical cooperation;

Regretting that the various official languages and the working languages are still used unequally within WHO;

Reaffirming the need to ensure high-quality translation of documents into all official languages of the Organization;

Considering that the preparation and distribution of the essential technical information of the Organization, such as the WHO guidelines, in the six official languages is one of the fundamental conditions for equality among Member States;

Stressing the need to achieve full parity among the six official languages including on the WHO internet site,

REQUESTS the Director-General:

- (1) to take into account recommendations contained in United Nations General Assembly resolution 71/328 and to work in cooperation with the United Nations Secretary-General's language services, including to develop cost-neutral approaches;
- (2) to apply the rules of the Organization that establish linguistic practice within the Secretariat in a cost-neutral, practical, efficient and cost-effective manner;
- (3) to ensure that all language services are given equal treatment and are provided with equally favourable working conditions and resources, with a view to achieving maximum quality of services;
- (4) to promote multilingualism in the daily work of the Secretariat and encourage staff to take advantage of technical and scientific literature generated in the maximum number of languages, both official and non-official, in a cost effective-manner;
- (5) to ensure that job descriptions specify the need for multilingual skills, including a working language of the Secretariat;
- (6) to appoint an officer who can serve as Coordinator for Multilingualism, who will be responsible, inter alia, for supervising and supporting the overall implementation of multilingualism, and to call upon all WHO departments to fully support the work of the Coordinator in the implementation of the relevant mandates on multilingualism;
- (7) to continue to improve and update in a cost-effective manner the WHO internet site in all official languages to make it more widely accessible and to develop a multilingual public communication strategy;
- (8) to take the necessary steps to ensure, including through improved planning and coordination, the timely translation into all official languages of the essential technical information of the Organization and WHO guidelines, whether in written, audiovisual or digital form, making such information more widely accessible without undue delay;

(9) to develop a report on the previous practices, possible technical options and solutions, including cost-effective, innovative measures and all programme and budgetary implications, to improve the current situation and ensure availability of the essential technical information of the Organization and WHO guidelines, whether in written, audiovisual or digital form in the six official languages, to be submitted for consideration by the Seventy-second World Health Assembly, through the Executive Board at its 144th session.

(Seventh plenary meeting, 26 May 2018 –
Committee B, third report)

WHA71.16 Polio myelitis: containment of polioviruses¹

The Seventy-first World Health Assembly,

Having considered the report on eradication of poliomyelitis;²

Recalling resolution WHA65.5 (2012) on poliomyelitis: intensification of the global eradication initiative and WHA68.3 (2015) on poliomyelitis, and in which the Health Assembly urged all Member States *inter alia* to implement appropriate containment of all polioviruses starting with the serotype 2;

Noting the eradication of wild poliovirus type 2 globally, declared by the Global Commission for the Certification of the Eradication of Poliomyelitis in September 2015;

Acknowledging the continued progress in eradicating poliovirus types 1 and 3;

Recognizing the successful globally synchronized switch in April 2016 from the use of trivalent to bivalent oral polio vaccine, active only against poliovirus types 1 and 3;

Noting the development of the Polio Eradication and Endgame Strategic Plan 2013–2018, including objective 3 – containment and certification, considered by the Sixty-sixth World Health Assembly;³

Commending the work of WHO and the Global Commission for the Certification of the Eradication of Poliomyelitis in promoting the containment of all polioviruses, starting with type 2, the first serotype being eradicated;

Noting with alarm delays in implementation and certification of poliovirus containment for type 2 polioviruses planned for 2016, as well as the accidental release of wild poliovirus type 2 from a vaccine-production facility in 2017;

Underscoring the urgent need to accelerate globally activities to implement and certify containment of polioviruses;

Underlining that successful containment of all polioviruses will ensure the long-term sustainability of the eradication of poliomyelitis,

¹ See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

² Document A71/26.

³ Document WHA66/2013/REC/3, summary records of the ninth meeting of Committee A, section 1.

1. URGES all Member States:¹
 - (1) to fully implement all strategic approaches outlined in the Polio Eradication and Endgame Strategic Plan 2013–2018;
 - (2) to intensify efforts to accelerate the progress of poliovirus containment certification as outlined in national requirements² as well as in the WHO Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use (GAPIII);³
 - (3) to complete inventories for type 2 polioviruses, destroy unneeded type 2 materials and to begin inventories and destruction of unneeded type 1 and 3 materials in accordance with the latest available published WHO guidance;
 - (4) to ensure that any confirmed event associated with a breach in poliovirus containment is immediately reported to the National IHR Focal Point;
2. URGES all Member States retaining polioviruses:
 - (1) to reduce to a minimum the number of facilities designated for the retention of polioviruses, prioritizing facilities performing critical national or international functions;
 - (2) to appoint, as soon as possible and no later than the end of 2018, a competent national authority for containment⁴ that will process containment certification applications submitted by the facilities designated to store and/or handle poliovirus post-eradication and communicate its contact details to WHO by 31 March 2019;
 - (3) to make available to the national authority for containment all necessary resources, including technical, personnel and financial, required for the full and successful certification of implementation of appropriate poliovirus containment measures;
 - (4) to request facilities designated to retain poliovirus type 2 to formally engage in the Containment Certification Scheme⁵ by submitting to their national authorities for containment their applications for participation, which is the first step of the global certification process, as soon as possible and no later than 31 December 2019;⁴
 - (5) to initiate steps for the containment for wild type 1 and 3 materials so that, by the time of global certification of eradication, all facilities retaining poliovirus meet containment requirements;

¹ And, where applicable, regional economic integration organizations.

² Containment Advisory Group, see <http://polioeradication.org/tools-and-library/policy-reports/advisory-reports/containment-advisory-group/> (accessed 1 March 2018).

³ Available at http://polioeradication.org/wp-content/uploads/2016/12/GAPIII_2014.pdf (accessed 1 March 2018).

⁴ As recommended at the Special Meeting of the Global Commission for the Certification of the Eradication of Poliomyelitis on Poliovirus Containment (Geneva, 23–25 October 2017); the meeting report is available at <http://polioeradication.org/wp-content/uploads/2018/01/polio-global-certification-commission-report-2017-10-final-en.pdf> (accessed 1 March 2018).

⁵ Available at http://polioeradication.org/wp-content/uploads/2017/03/CCS_19022017-EN.pdf (accessed 26 May 2018).

(6) to prepare a national response framework for use in the event of a breach of poliovirus containment and risk of community exposure and to conduct a polio outbreak simulation exercise that covers the risk of poliovirus release from a facility;

3. REQUESTS the Director-General:

(1) to provide technical support to Member States in their efforts to implement poliovirus containment safeguards and certify that facilities retaining poliovirus meet the requirements outlined in the WHO Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use (GAPIII);

(2) to facilitate the harmonization of certification mechanisms for the long-term sustainability of the implementation of poliovirus containment in the post-eradication era;

(3) to update all WHO's recommendations and guidance on poliovirus containment, as and when needed;

(4) to report regularly to the Executive Board and the Health Assembly on progress and on the status of global poliovirus containment, aligned with other polio reporting requirements.

(Seventh plenary meeting, 26 May 2018 –
Committee B, fourth report)

DECISIONS

WHA71(1) **Composition of the Committee on Credentials**

The Seventy-first World Health Assembly appointed a Committee on Credentials consisting of delegates of the following Member States: Bahrain, El Salvador, Iceland, Jamaica, Lesotho, Mongolia, Nepal, Niger, Sao Tome and Principe, Serbia, Solomon Islands and Turkmenistan.

(First plenary meeting, 21 May 2018)

WHA71(2) **Election of officers of the Seventy-first World Health Assembly**

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

President: Dr Pagwesese David Parirenyatwa (Zimbabwe)

Vice-Presidents: Dr F. Duque III (the Philippines)
 Ms K. Abdul Samad Abdulla (Maldives)
 Dr Y. Birtanov (Kazakhstan)
 Dr D. Elmi Okieh (Djibouti)
 Dr R. Sánchez Cárdenas (Dominican Republic)

(First plenary meeting, 21 May 2018)

WHA71(3) **Election of officers of the main committees**

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

Committee A: Chairman Mr Arun Singhal (India).
Committee B: Chairman Dr Feroz Firozuddin (Afghanistan).

(First plenary meeting, 21 May 2018)

The main committees subsequently elected the following officers:

Committee A: Vice-Chairmen Dr Søren Brostrøm (Denmark)
 Mrs Mónica Martínez Menduño (Ecuador)

Rapporteur Dr Alain Etoundi Mballa (Cameroon)

Committee B: Vice-Chairmen Dr Stewart Jessamine (New Zealand)
 Professor Nicolas Méda (Burkina Faso)

Rapporteur Dr José Eliseo Orellana (El Salvador)

(First meetings of Committees A and B,
21 and 23 May 2018, respectively)

WHA71(4) Establishment of the General Committee

The Seventy-first World Health Assembly elected the delegates of the following 17 countries as members of the General Committee: Argentina, Barbados, Botswana, Bulgaria, China, Cuba, Fiji, France, Gabon, Madagascar, Mauritania, Nigeria, Russian Federation, Somalia, Turkey, United Kingdom of Great Britain and Northern Ireland and United States of America.

(First plenary meeting, 21 May 2018)

WHA71(5) Adoption of the agenda

The Seventy-first World Health Assembly adopted the provisional agenda prepared by the Executive Board at its 142nd session, with the deletion of six items and the exclusion of one supplementary item, and the transfer of one report from item 20 to item 12.

(Second plenary meeting, 21 May 2018)

WHA71(6) Verification of credentials

The Seventy-first World Health Assembly recognized the validity of the credentials of the following delegations: Afghanistan; Albania; Algeria; Andorra; Angola; Antigua and Barbuda; Argentina; Armenia; Australia; Austria; Azerbaijan; Bahamas; Bahrain; Bangladesh; Barbados; Belarus; Belgium; Belize; Benin; Bhutan; Bolivia (Plurinational State of); Bosnia and Herzegovina; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cabo Verde; Cambodia; Cameroon; Canada; Central African Republic; Chad; Chile; China; Colombia; Comoros; Congo; Cook Islands; Costa Rica; Côte d'Ivoire; Croatia; Cuba; Cyprus; Czechia; Democratic People's Republic of Korea; Democratic Republic of the Congo; Denmark; Djibouti; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Eritrea; Estonia; Eswatini; Ethiopia; Fiji; Finland; France; Gabon; Gambia; Georgia; Germany; Ghana; Greece; Grenada; Guatemala; Guinea; Guinea-Bissau; Guyana; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Kyrgyzstan; Lao People's Democratic Republic; Latvia; Lebanon; Lesotho; Liberia; Libya; Lithuania; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; Marshall Islands; Mauritania; Mauritius; Mexico; Micronesia (Federated States of); Monaco; Mongolia; Montenegro; Morocco; Mozambique; Myanmar; Namibia; Nauru; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; 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; San Marino; Sao Tome and Principe; Saudi Arabia; Senegal; Serbia; Seychelles; Sierra Leone; Singapore; Slovakia; Slovenia; Solomon Islands; Somalia; South Africa; South Sudan; Spain; Sri Lanka; Sudan; Suriname; Sweden; Switzerland; Syrian Arab Republic; Tajikistan; Thailand; The former Yugoslav Republic of Macedonia; 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, 23 May 2018 and
sixth plenary meeting, 25 May 2018)

WHA71(7) Election of Members entitled to designate a person to serve on the Executive Board

The Seventy-first World Health Assembly, after considering the recommendations of the General Committee, elected the following as Members entitled to designate a person to serve on the Executive Board: Australia, Chile, China, Djibouti, Finland, Gabon, Germany, Indonesia, Israel, Romania, Sudan, United States of America.

(Sixth plenary meeting, 25 May 2018)

WHA71(8) Addressing the global shortage of, and access to, medicines and vaccines¹

The Seventy-first World Health Assembly, having considered the report on addressing the global shortage of, and access to, medicines and vaccines,² decided to request the Director-General:

- (1) to elaborate a road map report, in consultation with Member States, outlining the programming of WHO's work on access to medicines and vaccines, including activities, actions and deliverables for the period 2019–2023;
- (2) to submit this road map report to the Seventy-second World Health Assembly for its consideration in 2019, through the Executive Board at its 144th session.

(Sixth plenary meeting, 25 May 2018 –
Committee A, first report)

WHA71(9) Global strategy and plan of action on public health, innovation and intellectual property: overall programme review¹

The Seventy-first World Health Assembly, having considered the report by the Director-General regarding the overall programme review of the global strategy and plan of action on public health, innovation and intellectual property,³ and its annex, decided:

- (1) to urge Member States to implement, as appropriate and taking into account national contexts, the recommendations of the review panel⁴ that are addressed to Member States and consistent with the global strategy and plan of action on public health, innovation and intellectual property;
- (2) to urge Member States also to further discuss the recommendations of the review panel not emanating from the global strategy and plan of action on public health, innovation and intellectual property;

¹ See Annex 8 for the financial and administrative implications for the Secretariat of this decision.

² Document A71/12.

³ Document A71/13.

⁴ See Annex 5.

(3) to request the Director-General to implement the recommendations addressed to the Secretariat as prioritized by the review panel, in an implementation plan, consistent with the global strategy and plan of action on public health, innovation and intellectual property;

(4) to further request the Director-General to submit a report on progress made in implementing this decision to the Seventy-third World Health Assembly in 2020.

(Sixth plenary meeting, 25 May 2018 –
Committee A, first report)

WHA71(10) Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan¹

The Seventy-first World Health Assembly, taking note of the report by the Director-General requested in decision WHA70(12) 2017,² 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-second World Health Assembly;

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

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

(4) 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;

(5) 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 and maintaining strong primary health care with integrated complete appropriate health services; and

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

(Sixth plenary meeting, 25 May 2018 –
Committee B, first report)

¹ See Annex 8 for the financial and administrative implications for the Secretariat of this decision.

² Document A71/27.

WHA71(11) Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits¹

The Seventy-first World Health Assembly, having considered the report by the Director-General on progress to implement decision WHA70(10) (2017),² approved the recommendations contained therein at paragraph 19,³ and requested that the final text of the analysis, requested under paragraph 8(b) of decision WHA70(10), be submitted to the Seventy-second World Health Assembly, through the Executive Board at its 144th session.

(Seventh plenary meeting, 26 May 2018 –
Committee B, third report)

WHA71(12) WHO programmatic and financial reports for 2016–2017, including audited financial statements for 2017

The Seventy-first World Health Assembly, having considered the WHO Results Report for the Programme budget 2016–2017 and the audited financial statements for 2017;⁴ and having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-first World Health Assembly,⁵ decided to accept the WHO Results Report for the Programme budget 2016–2017 and the audited financial statements for 2017.

(Seventh plenary meeting, 26 May 2018 –
Committee B, second report)

WHA71(13) Report of the External Auditor

The Seventy-first World Health Assembly, having considered the report of the External Auditor to the Health Assembly;⁶ and having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-first World Health Assembly,⁷ decided to accept the report of the External Auditor to the Health Assembly.

(Seventh plenary meeting, 26 May 2018
Committee B, second report)

WHA71(14) Appointment of representatives to the WHO Staff Pension Committee

The Seventy-first World Health Assembly nominated Dr Assad Hafeez of the delegation of Pakistan and Dr Alan Ludowyke of the delegation of Sri Lanka, as members for the remainder of their terms of office until May 2020.

¹ See Annex 8 for the financial and administrative implications for the Secretariat of this decision.

² Document A71/24.

³ See Annex 6.

⁴ Documents A71/28 and A71/29.

⁵ Document A71/45.

⁶ Document A71/32.

⁷ Document A71/48.

The Health Assembly also nominated Dr Chieko Ikeda of the delegation of Japan and Dr Christoph Hauschild of the delegation of Germany as alternate members of the WHO Staff Pension Committee for three-year terms until May 2021.

(Seventh plenary meeting, 26 May 2018 –
Committee B, second report)

WHA71(15) Implementation of the International Health Regulations (2005): five-year global strategic plan to improve public health preparedness and response, 2018–2023¹

The Seventy-first World Health Assembly, having considered the draft five-year global strategic plan to improve public health preparedness and response;² recalling decision WHA70(11) (2017), in which the Seventieth World Health Assembly took note of the report contained in document A70/16 on implementation of the International Health Regulations (2005): global implementation plan and requested the Director-General, *inter alia*, “to develop, in full consultation with Member States, including through the regional committees, a draft five-year global strategic plan to improve public health preparedness and response, based on the guiding principles contained in Annex 2 of document A70/16,³ to be submitted for consideration and adoption by the Seventy-first World Health Assembly, through the Executive Board at its 142nd session”; recalling that Member States may use any voluntary monitoring and evaluation instruments, including those referenced in the five-year global strategic plan; and appreciating the contribution of Member States to the extensive consultative process to develop the draft five-year global strategic plan, including discussions at the sessions of all six regional committees in 2017, the web-based consultation conducted by the Secretariat between 19 September and 13 October 2017, and the consultation of Member States, through the Permanent Missions in Geneva, organized on 8 November 2017,

(1) decided:

(a) to welcome with appreciation the five-year global strategic plan to improve public health preparedness and response, noting that this does not create any legally binding obligations for Member States, and mindful of the legally binding nature of the International Health Regulations (2005) obligations;

(b) that States Parties and the Director-General shall continue to report annually to the Health Assembly on the implementation of the International Health Regulations (2005), using the self-assessment annual reporting tool;

(2) requested the Director-General:

(a) to provide the necessary financial and human resources to support the implementation of the five-year global strategic plan, and, as necessary, its adaptation to regional contexts and existing relevant frameworks;

¹ See Annex 8 for the financial and administrative implications for the Secretariat of this decision.

² Document A71/8.

³ See Annex 7.

(b) to continue to submit every year a single report to the Health Assembly on progress made in implementation of the International Health Regulations (2005), containing information provided by States Parties and details of the Secretariat's activities, pursuant to paragraph 1 of Article 54 of the International Health Regulations (2005);

(c) to continue to provide support to Member States to build, maintain and strengthen core capacities under the International Health Regulations (2005).

(Seventh plenary meeting, 26 May 2018 –
Committee A, third report)

WHA71(16) Selection of the country in which the Seventy-second World Health Assembly would be held

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

(Seventh plenary meeting, 26 May 2018)

ANNEXES

ANNEX 1

WHO Global Conference on Noncommunicable Diseases Pursuing policy coherence to achieve SDG target 3.4 on NCDs (Montevideo, Uruguay, 18–20 October 2017)

MONTEVIDEO ROADMAP 2018–2030 ON NCDs AS A SUSTAINABLE DEVELOPMENT PRIORITY¹

[WHA71.2, Annex – 26 May 2018]

1. We, Heads of State and Government, Ministers and representatives of State and Government participating in this Conference, have come together to restate our commitment to take bold action and accelerate progress to, by 2030, reduce by one third the premature mortality from non-communicable diseases (NCDs) in line with the 2030 Agenda for Sustainable Development. We continue to be inspired by the action catalysed by the 2011 Political Declaration of the UN General Assembly on NCDs, and the WHO Global Action Plan for the Prevention and Control of NCDs 2013–2020. We reaffirm our commitment to their implementation, according to national context.
2. We acknowledge that premature mortality from NCDs² continues to constitute one of the major challenges for development in the 21st century, driven by economic, environmental and social determinants of health. Despite the remarkable progress achieved in some countries or regions, this has been highly uneven and insufficient to reach the global target on NCDs. Each year, 15 million people between the ages of 30 and 69 years die from an NCD; over 80% of these premature deaths occur in developing countries, disproportionately affecting the poorest and those furthest behind. Implementing coherent policies and ensuring that cost-effective, affordable and evidenced-based NCD interventions are available to all countries, according to national context and priorities, can reduce inequities and premature deaths from NCDs.
3. We recognize the importance of SDG 3 and ensuring that people not just survive, but live long and healthy lives, as well as the importance of preventing NCDs as specified in SDG target 3.4 on NCDs in achieving this overall goal. We also recognize that there are obstacles that countries must overcome to achieving SDG target 3.4.³ Addressing the complexity of the main risk factors, namely: tobacco use, physical inactivity, harmful use of alcohol and unhealthy diets, as well as air pollution, and the determinants of NCDs, including health literacy, requires multisectoral responses which are challenging to develop and implement, particularly when robust monitoring of NCD risk factors is absent at country level. Consequently, successful action requires enhanced political leadership to advance strategic,

¹ See resolution WHA71.2.

² Mainly four types of noncommunicable diseases (NCDs): cardiovascular diseases, cancers, chronic respiratory diseases and diabetes.

³ By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being.

outcome-oriented action across sectors and policy coherence for the prevention and control of NCDs, in line with whole-of-government and health-in-all-policies approaches.

4. One obstacle at country level is the lack of capacity to effectively address public health goals when they are in conflict with private sector interests, in order to effectively leverage the roles and contributions of the diverse range of stakeholders in combatting NCDs. Policies to prevent and control NCDs, including effective regulatory and fiscal measures, may be negatively influenced by private sector and other non-State actors' interests, and may be subject to legal disputes or other means to delay, curtail or prevent their effective use to reach public health goals. Health systems need to improve NCD prevention, diagnosis and management and to strengthen effective health promotion over the life course, as part of efforts to achieve universal health coverage and reduce health inequities, including in the context of population ageing. Reducing NCDs should be a higher priority across the relevant UN Agencies, NGOs, philanthropic foundations and academic institutions. The increasing disease burden from NCDs should be taken fully into account in international cooperation and development policies with a view to address the unmet demand for technical cooperation to strengthen national capacities.

5. Unless coherent political action to address these obstacles is accelerated, engaging across sectors and across stakeholders, the current rate of decline in premature mortality from NCDs is insufficient to meet SDG 3.4 by 2030. In order to address the premature mortality and excess morbidity caused by NCDs, we commit to pursue these actions:

Reinvigorate political action

6. We will continue to address the complexity and challenging nature of developing and implementing coherent multisectoral policies across government through a health-in-all-policies approach in order to achieve improved outcomes from the perspectives of health, health equity and health system functioning.

7. We will prioritize the most cost-effective, affordable, equitable and evidence-based interventions that will bring the highest public health return on investment, in accordance with national context and priorities. We will emphasize health as a political priority, with measures that address the impact of the major NCD risk factors, including regulation, standard setting and fiscal policies and other measures that are consistent with countries' domestic legal frameworks and international obligations.

8. We will act across relevant government sectors to create health-conducive environments and identify opportunities to establish concrete cross-sectoral commitments in order to promote co-benefits and to reduce negative impacts on health, including through health impact assessments. We will encourage NCDs implementation research to enhance the operationalization of national strategies and integrate them, where possible, within wider health sector strategic planning. We will work collaboratively to share and improve the implementation of best practices towards implementing innovative approaches to ensure improved surveillance and monitoring systems to support these actions.

Enable health systems to respond more effectively to NCDs

9. We will strengthen, as necessary, essential population level, people-centred public health functions and institutions for effective prevention and control of NCDs, including palliative care, and to promote mental health and wellbeing.

10. We will continue investing in health workers as an essential part of strengthening health systems and social protection. We will work to ensure a highly skilled, well-trained and well-resourced health workforce to lead and implement actions to promote health and prevent and control NCDs.
11. We commit to improve implementation of cost-effective measures of health promotion, including health literacy, and disease prevention throughout the lifecycle, early detection, health surveillance, and reduction of risk factors, including exposure to environmental risk factors, and sustained efforts to address people at risk, as well as the treatment and care for people with NCDs.
12. Recognizing that mental disorders and other mental health conditions contribute to the global NCD burden and that people with mental disorders and other mental health conditions have an increased risk of other NCDs and higher rates of morbidity and mortality, we commit to implementing measures to improve mental health and well-being, address their social determinants and other health needs and human rights of people with mental disorders and other mental health conditions and prevent suicides as part of a comprehensive response to NCDs.
13. We will work towards enhancing synergies in preventing and controlling communicable diseases and NCDs at the national, regional, and global levels, where appropriate, recognizing the opportunity to achieve gains through integrated approaches.
14. We will work to ensure the availability of resources and strengthen the capacity to respond more effectively and equitably to NCDs as part of Universal Health Coverage, including through strengthened community-level prevention and health services delivery and access to essential NCD medicines and technologies for all. In our health systems, we will strive to secure access to quality basic and specialised health services, including with financial risk protection in order to avoid social and economic hardship.
15. Recalling previous commitments, we will better measure and respond to the critical differences in specific risk factors and determinants affecting morbidity and mortality from NCDs for children, adolescents, women and men across the life course, and pursue and promote gender-based approaches for the prevention and control of NCDs to address these critical differences. We invite WHO to provide guidance on how to accelerate the implementation of national efforts to address the critical differences in the risks of morbidity and mortality from NCDs for men and women, boys and girls.

Increase significantly the financing of national NCD responses and international cooperation

16. We acknowledge that national NCDs responses – supported through domestic, bilateral and multilateral channels – require adequate, predictable and sustained financing, commensurate with the global health and socioeconomic burden they impose. We will start by prioritizing domestic budgetary allocations for addressing NCDs, where possible.
17. Where needed, we will work on national investments cases for the prevention and control of NCDs, their risk factors and determinants, to create the fiscal space for action. We will consider applying policy options that, in addition to having a positive effect on reducing the occurrence of NCDs throughout the life course, also have the capacity to generate complementary revenues to finance national NCD responses, as appropriate. These options may include, consistent with national policies and international obligations, taxation, including of tobacco as well as other products. We will continue to explore other complementary financing options, including voluntary innovative financing mechanisms, as appropriate.

18. We call upon UN agencies and other global health actors to scale up support to governments in developing and implementing the national responses for the prevention and control of NCDs, including palliative care aligned with national priorities. We look to WHO to continue to exercise its global leadership and coordination role and to explore how existing mechanisms could best be leveraged to identify and share information on existing and potential sources of finance and development cooperation mechanisms for the prevention and control of NCDs at the local, national, regional and global levels to support action to reach SDG 3.4 on NCDs and better integrate NCDs into development funding mechanisms.

19. NCDs can perpetuate poverty. For the poor and near poor, chronic illness and disability can be an economic catastrophe. Hard fought economic gains can be quickly wiped out, especially when diagnosis, treatment, and palliative care services are not available or accessible. Women face a double NCD burden, often assuming gender-based roles as unpaid caregivers for the sick. We will take action on the impacts of NCDs on poverty and development using gender-based approaches. We strongly encourage including the prevention and control of NCDs in Official Development Assistance to complement domestic resources and catalyse additional resources for action, including research.

Increase efforts to engage sectors beyond health

20. We acknowledge that working constructively with public sectors beyond health is essential in reducing NCD risk factors and achieving health gains to reduce premature deaths from NCDs. In addition, we recognize the interconnectedness between the prevention and control of NCDs and the achievement of the SDGs beyond target 3.4, including targets related to poverty, substance abuse, nutrition, hazardous environmental exposure, sustainable cities and others. Coordinated upstream action across sectors, including agriculture, environment, industry, trade and finance, education and urban planning, as well as research, will help to create a healthy and enabling environment that promotes effective, coherent policies and supports healthy behaviours and lifestyles. The health sector has a role to play in advocating for these actions, presenting evidence-based information, supporting health impact assessments and providing policy reviews and analyses on how decisions impact health, including implementation research with a view to increase and scale up implementation of best practices. We therefore commit to strong leadership and to fostering collaboration among sectors to implement policies to achieve shared goals.

21. We will enhance policy and legal expertise to develop NCDs responses in order to achieve the SDGs. We call upon the UN Inter-Agency Task Force on the Prevention and Control of NCDs and its Members, within their mandates, to scale up and broaden intersectoral work integrating expertise relevant to public health-related legal issues into NCD country support, including by providing evidence, technical advice, and case studies relevant to legal challenges. We encourage the UN Inter-Agency Task Force on the Prevention and Control of NCDs to explore the relationship between NCDs and the law to improve support to Member States in this area and to raise the priority it gives to this work.

22. We recognize that access to education that promotes health literacy at all levels of society and contexts is a key determinant of health. In particular, the school environment will be enabled to provide evidence-based education, including information and skills. We will improve awareness-raising on health and well-being throughout society, including the prevention and control of NCDs supported through public awareness campaigns and health-conducive environments that make the healthy choice the easier choice and facilitate behavioural changes. Besides the general responsibility of relevant sectors to promote health, it is in particular the task of the health sector to develop and provide appropriate information to increase health literacy.

23. We will scale up efforts to use information and communication technologies, including e-health and m-health, and other non-traditional and innovative solutions, to accelerate action towards achieving SDG target 3.4 by 2030.

24. We are concerned that the increased production and consumption of energy-dense, nutrient poor foods has contributed to diets that are high in saturated fats, sugars and salts. We will work towards advancing the implementation of global strategies and recommendations that aim at strengthening national food and nutrition policies, and their monitoring. This would include, inter alia, developing guidelines and recommendations that support and encourage healthy diets throughout the life course of our citizens, increasing the availability and affordability of healthy, safe nutritious food, including fruits and vegetables, while enabling healthier food choices as part of a balanced diet, and ensuring access to clean and safe drinking water. We call on WHO and FAO and other relevant international organizations to fully leverage the UN Decade of Action on Nutrition to promote health-conducive food production and supply systems reduce diet-related NCDs and contribute to ensure healthy diets for all.

25. We call on WHO to fast-track its review of national and regional experience of intersectoral policies to achieve SDG 3, and particularly target 3.4 on NCDs, to update its guidance on multisectoral and multi-stakeholder action for the prevention and control of NCDs and disseminate knowledge and best practices through WHO GCM/NCD's¹ communities of practice in a manner supportive of action at country level.

Reinforce the role of non-State actors

26. We acknowledge the need to engage with non-State actors in view of their significant role for the advancement and promotion of the highest attainable standard of health and to encourage non-State actors to use their own activities to protect and promote public health, in line with national context and priorities.

27. We will increase opportunities for meaningful participation of, where and as appropriate, nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions, in building coalitions and alliances across the spheres of sustainable development in the prevention and control of NCDs, recognizing that they can complement the efforts of governments at varying levels and support the achievement of SDG target 3.4, in particular in developing countries.

28. We call on the private sector, ranging from micro-enterprises to cooperatives to multinationals, to contribute to addressing NCDs as a development priority, in the context of the achievement of the SDGs, in particular SDG 17.²

Seek measures to address the negative impact of products and environmental factors harmful for health and strengthen the contribution and accountability of the private sector and other non-State actors

29. One notable challenge for the prevention and control of NCDs is that public health objectives and private sector interests can conflict. We commit to enhancing the national capacity to engage constructively with the private sector for NCDs prevention and control in a way that maximizes public health benefits.

¹ WHO Global Coordination Mechanism on the Prevention and Control of NCDs (WHO GCM/NCD).

² Strengthen the means of implementation and revitalize the global partnership for sustainable development.

30. We acknowledge that we need to continue to develop coordinated and coherent policies, strengthen evidence-based policy and regulatory frameworks, and align private sector incentives with public health goals, to make health conducive choices available and affordable in healthy environments, and in particular, to empower and provide people with the necessary resources and knowledge, including health literacy, in order to enable healthy choices and active lifestyles.

31. We further encourage the private sector to produce and promote more food and beverage products consistent with a healthy diet including by reformulating products, especially those products with the largest impacts on health, to provide healthier options that are affordable and accessible for all and that follow appropriate nutrition facts and labelling standards, including information on sugars, salt and fats and, where relevant, trans-fat content. We also encourage the private sector to reduce the exposure of and impact on children of marketing of foods and non-alcoholic beverages, consistent with WHO recommendations and guidance, and in accordance with national legislation, policies, and relevant international obligations.

32. We acknowledge the importance of improving environmental determinants and reducing risk factors in the prevention and control of NCDs and the inter linkage of SDG targets 3.4 and 3.9.¹ These interlinkages illustrate that the prevention and control NCDs can also contribute positively to the SDG goal 13 on climate change. We will promote actions that are mutually reinforcing and support achievement of these goals and targets.

33. We will continue to work with all stakeholders, including industry, food business operators, health and consumer NGOs, and academia, towards the achievement of the nine voluntary NCD targets for 2025. This may include, as appropriate, promoting the recording and making publicly available of the verifiable commitments of non-State actors, as well as their reporting on the implementation of those commitments. We call on WHO to continue the development of expertise, tools, guidance and approaches that can be used to register and publish contributions of non-State actors in the achievement of these targets, and to assist Member States in effectively engaging non-State actors and leveraging their strengths in the implementation of national NCD responses.

34. We call upon States parties, to accelerate the full implementation of the WHO Framework Convention on Tobacco Control, as one of the cornerstones of the global response to NCDs and encourage countries that have not yet done so to consider becoming a Party to the Convention. Recognizing the fundamental and irreconcilable conflict of interest between the tobacco industry and public health, we will continue to implement tobacco control measures without any tobacco industry interference.

35. We encourage the WHO GCM/NCD to explore the impact of economic, market and commercial factors on the prevention and control of NCDs to better improve the understanding of their implications for health outcomes and opportunities to advance action in the global NCD agenda.

Continue relying on WHO's leadership and key role in the global response to NCDs

36. We reaffirm WHO as the directing and coordinating authority on international health work and all its functions in this regard, including its normative work and convening role. WHO's support is essential in the development of national NCD and mental health responses as an integral part of the implementation of the 2030 Agenda for Sustainable Development. WHO's advice to Member States on

¹ By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.

how to address the determinants and risk factors remains indispensable for the global action on NCDs and mental health.

37. We also reaffirm WHO's leadership and coordination role in promoting and monitoring global action against NCDs in relation to the work of other UN agencies, development banks, and other regional and international organizations in addressing NCDs in a coordinated manner.

38. We call on WHO to strengthen its capacity to provide technical and policy advice and enhance multistakeholder engagement and dialogue, through platforms such as the WHO GCM/NCD and the UN Inter-Agency Task Force on NCDs.

39. We further call on WHO to consider prioritizing the implementation of strategic actions, including cost-effective and evidence-based policies and interventions, in preparation of the third United Nations High-level Meeting on NCDs in 2018.

Act in unity

40. We acknowledge that the inclusion of NCDs in the 2030 Agenda for Sustainable Development provides the best opportunity to place health and in particular NCDs at the core of the pursuit of shared progress and sustainable development. Ultimately, the aspiration of the 2030 Agenda is to create a just and prosperous world where all people can exercise their rights and live long and healthy lives.

41. Acting in unity to address NCDs demands a renewed and strengthened commitment to show that we can be effective in shaping a world free of the avoidable burden of NCDs. In so doing, we will continue to listen to and involve the peoples of the world – those exposed to NCD risk factors, and those with health care needs for NCDs and mental health. We will continue to build a future that ensures present and future generations enjoy the highest attainable standard of health and well-being.

ANNEX 2

First WHO global ministerial conference on “Ending tuberculosis in the sustainable development era: a multisectoral response” (Moscow, Russian Federation, 16–17 November 2017)

MOSCOW DECLARATION TO END TB¹

Preamble:

We, the Ministers of Health and from across Governments acknowledge that despite concerted efforts, tuberculosis (TB), including its drug-resistant forms, causes more deaths than any other infectious disease worldwide^a and is a serious threat to global health security.

TB kills more than five thousand children, women and men each day and leaves no country untouched.^a It is one of the leading killers among people of working age which creates and reinforces a cycle of ill-health and poverty, with potential catastrophic social and economic consequences for families, communities, and countries. While recognizing the higher prevalence of TB among men, women and children are also vulnerable to the consequences of TB due to gender- and age-related social and health inequalities, such as poor health literacy, limited access to health services, stigma and discrimination, and exposure to the infection as carers. Multidrug-resistant TB (MDR-TB) accounts for one-third of all antimicrobial resistance (AMR)-related deaths, making the global AMR agenda central to tackling TB. TB is also the principal cause of death among people living with HIV/AIDS. The global TB targets will not be met without new and more effective tools and innovative approaches for prevention, diagnosis, treatment and care. Persistent funding gaps impede progress towards ending TB.

Although a concern to all people, TB disproportionately afflicts the poorest and the most vulnerable populations. Tobacco smoking, harmful use of alcohol and other substance abuse, air pollution, exposure to silica dust, living with HIV/AIDS, diabetes and malnutrition increase the risk of TB. Stigma and discrimination remain critical barriers to TB care.

We reaffirm our commitment to end the TB epidemic by 2030 as envisaged in the Agenda 2030 for Sustainable Development and its Sustainable Development Goals (SDGs), the World Health Organization (WHO) End TB Strategy, and the Stop TB Partnership Global Plan to End TB 2016-2020. We acknowledge that to fundamentally transform the fight against TB, we need to:

- (i) address all the determinants^b of the TB epidemic including through a high-level commitment to, and implementation of, a multisectoral approach^c;
- (ii) achieve rapid progress towards the goal of universal health coverage through health systems strengthening, while also ensuring universal access to quality people-centred TB prevention and care, ensuring that no one is left behind;
- (iii) implement measures aimed at minimizing the risk of the development and spread of drug resistance taking into account global efforts to combat AMR;

¹ See resolution WHA71.3.

- (iv) secure sufficient and sustainable financing, especially from domestic sources, and mobilize, as needed, additional financing from development banks, development partners and donor agencies;
- (v) advance research and development, as well as rapid uptake, of new and more effective tools for diagnosis, treatment, drug regimens, and prevention including vaccination, and ensure that we translate existing and emerging knowledge into concrete action to achieve rapid results;
- (vi) actively engage people and communities affected by, and at risk of, TB.

Furthermore, an effective TB response requires a global, regional, cross-border and country specific approach with multisectoral and multi-stakeholder actions, with recognition of: (i) significant differences among and within countries with high, intermediate and low incidence of TB and MDR-TB, (ii) demographic and social trends such as population ageing and urbanization, and (iii) needs of the affected individuals and communities, and the challenges in reaching and identifying all people with TB and providing them with appropriate care.

We recognize this First WHO Global Ministerial Conference, *Ending TB in the Sustainable Development Era: A Multisectoral Response*, convened by the WHO and the Government of the Russian Federation, as a fundamental milestone towards the United Nations General Assembly (UNGA) High-Level Meeting on TB in 2018. To fulfil the commitments and calls to action in this Declaration, and to achieve the most from the UNGA High-Level Meeting, we need to enlist the full engagement of, and collaboration among, heads of state, UN leadership and other global leaders; technical agencies and academia; private sector and philanthropic foundations; civil society and other relevant partners (such as patients groups, health professionals, social and community workers organizations and funding agencies).

Commitments and calls to action:

We commit ourselves to ending TB, which is a political priority defined in the Agenda 2030 and as a contribution to achieving universal health coverage, within national legislative and policy frameworks, and to implementing the following actions through approaches protecting and promoting equity, ethics, gender equality, and human rights in addressing TB, and based on sound, evidence-based, public health principles. We urge WHO, and call upon other UN organizations and all partners, to provide the support necessary for success:

1) Advancing the TB response within the SDG agenda

We commit to:

- *Scaling up TB prevention, diagnosis, treatment and care and working towards the goal of universal health coverage through public and private health care providers to achieve detection of at least 90 per cent of cases and successful treatment of at least 90 per cent of those detected^d in all countries through the use of rapid diagnostics (including molecular diagnostics), appropriate treatment, patient-centred care and support, applying WHO-recommended standards of care^e, and harnessing digital health^f.*
- *Prioritizing, as appropriate, notably through the involvement of communities and civil society and in a non-discriminatory manner, high-risk groups and populations in vulnerable situations such as women and children, indigenous peoples, health care workers, the elderly, migrants, refugees, internally displaced people, prisoners, people living with HIV/AIDS, people who use*

drugs, miners, urban and rural poor and under-served populations, without which TB elimination will not be possible.

- *Addressing MDR-TB as a global public health crisis including through a national emergency response in at least all high MDR-TB burden countries, while ensuring that robust systems are sustained in all countries to prevent emergence and spread of drug resistance.*
- *Rapidly scaling up access to patient-centred, integrated TB and HIV services and collaborative activities to end preventable deaths due to TB among people living with HIV/AIDS.^{g h}*
- *Achieving synergies in managing TB, co-infections and relevant noncommunicable diseases, undernutrition, mental health and harmful use of alcohol and other substance abuse, including drug injection.*
- *Working to increase, when relevant, access to new and effective tuberculosis drugs under strict programmatic monitoring and follow-up.*
- *Ensuring, as appropriate, adequate human resources for TB prevention, treatment and care.*
- *Reducing stigma, discrimination and community isolation, and promoting patient-centred care including community-based treatment options, as well as psychosocial and socioeconomic support.*

We call upon:

- *WHO, other UN agencies, the Global Fund to Fight AIDS, TB and Malaria, the Stop TB Partnership, UNITAID, donors and partners, including from the private sector, academia and philanthropic foundations, and civil society to support the implementation of this declaration.*
- *WHO, bilateral and multilateral funding agencies and other partners to urgently support high MDR-TB burden countries in their national emergency response.*
- *WHO, other UN agencies, bilateral and multilateral funding agencies and technical partners to address MDR-TB as a major threat to public health securityⁱ by supporting implementation of the Global Action Plan on AMR in all countries, while we reaffirm the political declaration of the high-level meeting of the UN General Assembly on antimicrobial resistance.^j*

2) Ensuring sufficient and sustainable financing

We commit to:

- *Working with heads of state and across ministries and sectors, as appropriate, to mobilize the domestic financing needed for health systems strengthening with the ultimate goal of reaching universal health coverage, in keeping with national legislative frameworks, and with the Addis Ababa Action Agenda of the Third International Conference on Financing for Development.^k*
- *Developing and implementing, as appropriate, more ambitious, fully-funded national TB policies and strategic plans, including for TB research, that are aligned with national health plans, frameworks and the End TB Strategy and in keeping with national legislative frameworks.*
- *Identifying and implementing, as appropriate, the actions required to address issues that cause catastrophic costs^l to patients and their households, to ensure social protection measures, while ensuring that actions are in line with human rights obligations.*

We call upon:

- *Global health financing partners including the Global Fund to Fight AIDS, TB and Malaria, the Global Financing Facility, bilateral agencies, the World Bank, and regional development banks to pursue and advocate for additional financing including through blended^m and/or other*

forms of innovative financing, with adequate safeguards for ensuring public health impact and attention to key populations.

- *WHO to continue providing strategic and technical leadership, advice and support to Member States as well as to international institutions.*
- *Academic, technical, civil society, private sector and other relevant partners to continue their efforts to help countries develop and pursue investment cases^o while supporting health systems strengthening and increased absorption capacity.^o*

3) Pursuing science, research and innovation

We commit to:

- *Increasing national and/or regional capacity and funding, as needed, to urgently expand multidisciplinary TB research and innovation, as well as applied health research, by establishing and/or strengthening national TB research networks including civil society and community-based mechanisms, considering TB research as a central element of national TB and R&D strategies, expanding existing networks to integrate TB research, and reducing research- and implementation-related regulatory impediments.*
- *Working, when relevant, across ministries, donors, the scientific community and the private sector, academia, and other key stakeholders for the purpose of research: (a) for development and evaluation of (i) rapid point of care diagnostics, (ii) new and more effective drugs, and shorter, high-quality and cost-effective treatment regimens for all forms of TB (including latent TB infection and drug-resistant TB), and (iii) safe and effective TB vaccines by 2025; and (b) on environmental and social determinants of TB and effective interventions strategies.*
- *Improving, as appropriate, the coordination of research efforts nationally and globally, and ensuring that the emerging knowledge is promptly put into action, including by putting in place appropriate policy frameworks and implementing new medical technologies.*
- *Strengthening, as appropriate, surveillance systems, improving data collection and reporting at all levels, utilising innovative approaches and including surveillance in TB research agendas.*

We call upon:

- *WHO in collaboration with global partners, research organizations, donors, the scientific community and countries to consider developing a Global Strategy for TB Research taking into consideration ongoing and new efforts, such as the TB Research Network stated in the BRICS Leaders Xiamen Declaration.*
- *WHO in collaboration with global health and research partners and countries to make further progress in enhancing cooperation and coordination of TB research and development, considering where possible drawing on existing research networks to integrate TB research, such as the new AMR Research and Development Collaboration Hub proposed in the 2017 G20 Leaders' Declaration, notably to facilitate rapid scale up of innovative approaches and tools for TB prevention, diagnosis, treatment and care.*

4) Developing a Multisectoral Accountability Framework

To end TB by 2030, we will need reliable data to ensure that our collective knowledge is transformed into effective and timely action, both globally and domestically, and that we deliver on the commitments made in this declaration. A new multisectoral accountability framework should enable the review and monitoring of implementation and provide a systematic approach to determine additional actions required to achieve the SDG and End TB Strategy milestones and targets. The accountability framework should build upon evidence, independent analysis and constructive collaboration among all relevant

partners, with an emphasis on high-burden countries, and should avoid duplication and increased reporting burden. To maximize impact, a multisectoral accountability framework that is based on approaches protecting and promoting equity, gender equality, human rights and ethics could, according to needs, include:

- a) The convening of national inter-ministerial commissions on TB, or their equivalent, by Ministries of Health in partnership with civil society and, where appropriate, with the direct engagement of the Heads of State, and the consideration of expanding existing intersectoral fora to include actions against TB in consultation with existing entities the goals of which include combatting TB so as to avoid duplication of efforts;
- b) Mechanisms for strengthening advocacy at all levels within all relevant sectors;
- c) Well-defined reporting, including sex- and age-disaggregated data, and review processes to monitor progress toward clear goals; and
- d) Opportunities for active engagement, monitoring, reporting and/or audits by civil society, as well as other key stakeholders.

We commit to:

- *Supporting the development of a multisectoral accountability framework in advance of the 2018 UNGA High-Level Meeting on TB, to track progress towards the SDG target of ending TB using relevant SDG indicators and the End TB Strategy operational indicators, and applying financing benchmarks set by the Stop TB Partnership Global Plan to Stop TB 2016-2020.*

We call upon:

- *WHO, working in close cooperation with the UN Special Envoy on TB, Member States, including, where applicable, regional economic integration organizations, civil society representatives, UN Organizations, the World Bank and other multilateral development banks, UNITAID, the Stop TB Partnership, the Global Fund to Fight AIDS, TB and Malaria, research institutes and other partners, to develop the multisectoral accountability framework for the consideration of the WHO Governing Bodies, while taking into account existing multisectoral and multi-stakeholder frameworks, that enables measuring progress both globally and nationally through an independent, constructive and positive approach, especially in the highest burden countries, and an independent review of progress by those countries.*
- *WHO, in collaboration with Member States and key stakeholders, to develop a reporting framework and periodicity for a multisectoral global progress report on TB, subject to independent review.*

Way forward:

We conclude with a commitment to act immediately on this Declaration in coordination with the WHO, and to engage with leaders and all relevant sectors of Government, UN agencies, bilateral and multilateral funding agencies and donors, academia, research organizations, scientific community, civil society and the private sector to prepare for and follow-up on the UNGA High-Level Meeting on Tuberculosis in 2018 in New York.

Explanatory Notes

^a Please see the 2016 WHO Global TB Report: http://www.who.int/tb/publications/global_report/en/

^b TB determinants and/or risk factors: Conditions that favour transmission of TB or make people vulnerable to get TB are called TB determinants. The important social determinants of TB include poverty, and poor living and working conditions. Communicable and noncommunicable disease and other conditions that increase individual risk of getting TB are called risk factors. These include HIV/AIDS and other conditions that weaken the immune system, diabetes, silicosis, tobacco smoking, undernutrition, harmful use of alcohol and other substance abuse.

^c Multisectoral approach: Preventing TB or minimizing the risk of TB certainly requires not only actions by the health sector (such as achieving universal health coverage and control of communicable and noncommunicable diseases that are major risk factors for TB) but also by other development sectors (such as poverty reduction, improved food security, better living and working conditions).

^d As recommended in the WHO guidance on implementing the End TB Strategy: http://www.who.int/tb/publications/2015/end_tb_essential.pdf?ua=1

^e Standards of care: WHO-recommended standards for optimum delivery of TB care and prevention, presented in the *Compendium of WHO guidelines and associated standards: ensuring optimum delivery of the cascade of care for patients with TB*.

^f Please see the document, *WHO Digital health for the End TB Strategy - an agenda for action* <http://www.who.int/tb/publications/digitalhealth-TB-agenda/en/>

^g Eliminating preventable deaths among people living with HIV: This is in line with the target of reducing TB-related deaths among people living with HIV by 75 per cent by 2020, adopted by the UN General Assembly in the Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030.

^h Please see the document, *WHO policy on collaborative TB/HIV activities* http://www.who.int/tb/publications/2012/tb_hiv_policy_9789241503006/en/.

ⁱ As stated in *WHA Resolution 62.15* from 2009: “Concerned that the highest levels of multidrug-resistance reported in WHO’s fourth global report on anti-tuberculosis drug resistance – an estimated half a million multidrug-resistant cases occurring globally, including 50 000 cases of extensively drug-resistant tuberculosis – pose a threat to global public health security” http://apps.who.int/gb/ebwha/pdf_files/WHA62-REC1/WHA62_REC1-en-P2.pdf.

^j Please see the documents *WHO Global Action Plan on AMR* <http://www.who.int/antimicrobial-resistance/global-action-plan/en/> (adopted by the 68th WHA http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_R7-en.pdf?ua=1), and the *Political declaration of the high-level meeting of the UN General Assembly on AMR* http://www.un.org/pga/71/wp-content/uploads/sites/40/2016/09/DGACM_GAEAD_ESCAB-AMR-Draft-Political-Declaration-1616108E.pdf.

^k Please see the document, *Addis Ababa Action Agenda of the Third International Conference on Financing for Development* http://www.un.org/esa/ffd/wp-content/uploads/2015/08/AAAA_Outcome.pdf

^l Catastrophic costs: The costs due to TB measure the total economic burden on TB patients and their families and are considered catastrophic when they threaten the livelihood of patients and their families. These costs include: payments for care (e.g. diagnostic and treatment services, and medicines), payments associated with care seeking (e.g. travel costs) and the “opportunity costs” associated with care seeking (e.g. lost income). These are determined by undertaking surveys of TB patients in health facilities.

^m Blended financing: Complementary use of grants (such as from the Global Fund or other donors) and non-grant financing from private and/or public sources (such as a World Bank loan) on terms that would make a programme financially sustainable.

ⁿ Investment case: The Investment Case is a description of the transformation that a country wants to see to meet the targets and milestones towards ending the TB epidemic, and a prioritized set of investments required to achieve the results.

^o Absorption capacity: Capacity of a country health system to put a significantly increased flow of resources to efficient use, which depends generally on governance, institutional capacity, ownership, and social and political stability.

ANNEX 3

Strategic objectives and recommended policy actions of the global action plan on physical activity 2018–2030¹

[A71/18 – 22 March 2018]

<p>Strategic objective 1: Create an active society – social norms and attitudes</p> <p>Create a paradigm shift in all of society by enhancing knowledge and understanding of, and appreciation for, the multiple benefits of regular physical activity, according to ability and at all ages.</p>
<p>Action 1.1. Implement best practice communication campaigns, linked with community-based programmes, to heighten awareness, knowledge and understanding of, and appreciation for, the multiple health benefits of regular physical activity and less sedentary behaviour, according to ability, for individual, family and community well-being.</p>
<p>Action 1.2. Conduct national and community-based campaigns to enhance awareness and understanding of, and appreciation for, the social, economic, and environmental co-benefits of physical activity, and particularly more walking, cycling and other forms of mobility involving the use of wheels (including wheelchairs, scooters and skates) and thereby make a significant contribution to achievement of the 2030 Agenda for Sustainable Development (Sustainable Development Goals 2, 3, 4, 5, 9, 10, 11, 13, 15 and 16).</p>
<p>Action 1.3. Implement regular mass-participation initiatives in public spaces, engaging entire communities, to provide free access to enjoyable and affordable, socially and culturally appropriate experiences of physical activity.</p>
<p>Action 1.4. Strengthen pre- and in-service training of professionals, within and outside the health sector, to increase knowledge and skills related to their roles and contributions in creating inclusive, equitable opportunities for an active society including, but not limited to, the transport, urban planning, education, tourism and recreation, sports and fitness sectors, as well as in grass-roots community groups and civil society organizations.</p>
<p>Strategic objective 2: Create active environments – spaces and places</p> <p>Create and maintain environments that promote and safeguard the rights of all people, of all ages, to have equitable access to safe places and spaces, in their cities and communities, in which to engage in regular physical activity, according to ability.</p>
<p>Action 2.1. Strengthen the integration of urban and transport planning policies that prioritize the principles of compact, mixed land use, at all levels of government, as appropriate, to deliver highly connected neighbourhoods that enable and promote walking, cycling, other forms of mobility involving the use of wheels (including wheelchairs, scooters and skates) and the use of public transport, in urban, peri-urban and rural communities.</p>
<p>Action 2.2. Improve the level of service² provided by walking and cycling network infrastructure, to enable and promote walking, cycling, other forms of mobility involving the use of wheels (including wheelchairs, scooters and skates) and the use of public transport, in urban, peri-urban and rural communities, with due regard for the principles of safe, universal and equitable access by people of all ages and abilities, and in alignment with other commitments.³</p>

¹ See resolution WHA71.6.

² Level of service refers to the attributes of safety, quality, connectedness and completeness; assessment instruments for walking and cycling are available in many countries.

³ New Urban Agenda adopted in 2016 by the United Nations Conference on Housing and Sustainable Urban Development (Habitat III) and endorsed by the United Nations General Assembly in resolution 71/256 (2016). See also Planning and design for sustainable urban mobility: global report on human settlements 2013. Oxford: United Nations Human Settlements Programme (UN-Habitat); 2013.

Action 2.3. Accelerate implementation of policy actions to improve road safety and the personal safety of pedestrians, cyclists, people engaged in other forms of mobility involving the use of wheels (including wheelchairs, scooters and skates) and public transport passengers, with priority given to actions that reduce risk for the most vulnerable road users in accordance with the safe systems approach to road safety, and in alignment with other commitments.¹

Action 2.4. Strengthen access to good-quality public and green open spaces, green networks, recreational spaces (including river and coastal areas) and sports amenities by all people, of all ages and of diverse abilities in urban, peri-urban and rural communities, ensuring design is consistent with these principles of safe, universal, age-friendly and equitable access with a priority being to reduce inequalities.

Action 2.5. Strengthen the policy, regulatory and design guidelines and frameworks at the national and subnational levels, as appropriate, to promote public amenities, schools, health care, sports and recreation facilities, workplaces and social housing that are designed to enable occupants and visitors with diverse abilities to be physically active in and around the buildings, and prioritize universal access by pedestrians, cyclists and public transport.

Strategic objective 3: Create active people – programmes and opportunities

Create and promote access to opportunities and programmes, across multiple settings, to help people of all ages and abilities to engage in regular physical activity as individuals, families and communities.

Action 3.1. Strengthen provision of good-quality physical education and more positive experiences and opportunities for active recreation, sports and play for girls and boys, applying the principles of the whole-of-school approach in all pre-primary, primary, secondary and tertiary educational institutions, so as to establish and reinforce lifelong health and physical literacy, and promote the enjoyment of, and participation in, physical activity, according to capacity and ability.

Action 3.2. Implement and strengthen systems of patient assessment and counselling on increasing physical activity and reducing sedentary behaviour, by appropriately trained health, community and social care providers, as appropriate, in primary and secondary health care and social services, as part of universal health care, ensuring community and patient involvement and coordinated links with community resources, where appropriate.

Action 3.3. Enhance provision of, and opportunities for, more physical activity programmes and promotion in parks and other natural environments (such as beach, rivers and foreshores) as well as in private and public workplaces, community centres, recreation and sports facilities, and faith-based centres, to support participation in physical activity, by all people of diverse abilities.

Action 3.4. Enhance the provision of, and opportunities for, appropriately tailored programmes and services aimed at increasing physical activity and reducing sedentary behaviour in older adults, according to ability, in key settings such as local and community venues, health, social and long-term care settings, assisted living facilities and family environments, to support healthy ageing.

Action 3.5. Strengthen the development and implementation of programmes and services, across various community settings, that engage with, and increase the opportunities for physical activity in the least active groups, as identified by each country, such as girls, women, older adults, rural and indigenous communities, and vulnerable or marginalized populations, embracing positive contributions by all people.

¹ See the United Nations Global Plan for the Decade of Action for Road Safety 2011–2020 (http://www.who.int/roadsafety/decade_of_action/plan/en/, accessed 1 March 2018) and the United Nations General Assembly resolution 64/255 (2010) on improving global road safety (http://www.who.int/violence_injury_prevention/publications/road_traffic/UN_GA_resolution-54-255-en.pdf, accessed 1 March 2018); the United Nations Convention on the Rights of Child; the United Nations Convention on the Rights of Persons with Disabilities; Open-ended Working Group on Ageing for the purpose of strengthening the protection of the human rights of older persons, report of the eighth working session (<https://social.un.org/ageing-working-group/eighthsession.shtml>, accessed 23 February 2018); and the Global status report on violence prevention 2014. Geneva: World Health Organization; 2014, cosponsored by UNDP and UNODC (http://www.who.int/violence_injury_prevention/violence/status_report/2014/en/, accessed 1 March 2018).

<p>Action 3.6. Implement whole-of-community initiatives, at the city, town or community levels, that stimulate engagement by all stakeholders and optimize a combination of policy approaches, across different settings, to promote increased participation in physical activity and reduced sedentary behaviour by people of all ages and diverse abilities, focusing on grass-roots community engagement, co-development and ownership.</p>
<p>Strategic objective 4: Create active systems – governance and policy enablers Create and strengthen leadership, governance, multisectoral partnerships, workforce capabilities, advocacy and information systems across sectors to achieve excellence in resource mobilization and implementation of coordinated international, national and subnational action to increase physical activity and reduce sedentary behaviour.</p>
<p>Action 4.1. Strengthen policy frameworks, leadership and governance systems, at the national and subnational levels, to support implementation of actions aimed at increasing physical activity and reducing sedentary behaviour, including: multisectoral engagement and coordination mechanisms; policy coherence across sectors; guidelines, recommendations and actions plans on physical activity and sedentary behaviour for all ages; and progress monitoring and evaluation to strengthen accountability.</p>
<p>Action 4.2. Enhance data systems and capabilities at the national and, where appropriate, subnational level, to support: regular population surveillance of physical activity and sedentary behaviour, across all ages and multiple domains; development and testing of new digital technologies to strengthen surveillance systems; development of monitoring systems of the wider sociocultural and environmental determinants of physical activity; and regular multisectoral monitoring and reporting on policy implementation to ensure accountability and inform policy and practice.</p>
<p>Action 4.3. Strengthen the national and institutional research and evaluation capacity and stimulate the application of digital technologies and innovation to accelerate the development and implementation of effective policy solutions aimed at increasing physical activity and reducing sedentary behaviour.</p>
<p>Action 4.4. Escalate advocacy efforts to increase awareness and knowledge of, and engagement in, joint action at the global, regional and national levels, targeting key audiences, including but not limited to high-level leaders, policy-makers across multiple sectors, the media, the private sector, city and community leaders, and the wider community.</p>
<p>Action 4.5. Strengthen financing mechanisms to secure sustained implementation of national and subnational action and the development of the enabling systems that support the development and implementation of policies aimed at increasing physical activity and reducing sedentary behaviour.</p>

ANNEX 4

Deputy Directors-General¹

[A71/37 – 22 March 2018]

TEXT OF AMENDED STAFF REGULATIONS

STAFF REGULATIONS – ARTICLE I
Duties, Obligations and Privileges

...

1.11 The oath or declaration shall be made orally by the Director-General at a public meeting of the World Health Assembly, by each Deputy Director-General, Assistant Director-General and Regional Director before the Director-General and in writing by other staff members.

.....

STAFF REGULATIONS – ARTICLE III
Salaries and Related Allowances

3.1 The salaries for Deputy Director-General, Assistant Director-General and Regional Director shall be determined by the World Health Assembly on the recommendation of the Director-General and with the advice of the Executive Board.

.....

STAFF REGULATIONS – ARTICLE IV
Appointment, Transfer, Reassignment and Promotion

...

4.5 The appointment of each Deputy Director-General, Assistant Director-General and Regional Director shall be for a period not to exceed five years, subject to renewal, and in accordance with conditions determined by the Executive Board concerning eligibility of Regional Directors for reappointment. Other staff members shall be granted appointments of a duration and under such terms and conditions, consistent with these regulations, as the Director-General may prescribe.

¹ See resolution WHA71.11.

ANNEX 5

Global strategy and plan of action on public health, innovation and intellectual property¹

ACTIONS RECOMMENDED BY THE EXPERT PANEL FOR THE OVERALL PROGRAMME REVIEW OF THE GLOBAL STRATEGY AND PLAN OF ACTION ON PUBLIC HEALTH, INNOVATION AND INTELLECTUAL PROPERTY

[A71/13, Annex – 15 March 2018]

1. The terms of reference of the overall programme review requested the expert review panel to “recommend a way forward, including details of what elements or actions should be added, enhanced or concluded in the next stage of implementation of the global strategy and plan of action on public health, innovation and intellectual property, until 2022”.²
2. Although progress has been made in certain aspects of both innovation and access, many of the challenges that motivated formulation of the global strategy and plan of action on public health, innovation and intellectual property remain, and new challenges have emerged. These include a lack of new health products in areas of need and of sustainable financing, the unaffordability of many new medicines, a lack of essential health products and inappropriate use, ineffective delivery and supply chain infrastructure and the absence of robust regulatory frameworks and trained personnel, mainly but not exclusively in developing countries.
3. The review panel considered that the eight elements of the global strategy and plan of action on public health, innovation and intellectual property remain broadly valid. The main issue concerning the global strategy and plan of action has been its lack of impact in implementation. This suggested that the review could add most value by making recommendations that were more focused in terms of scope and scale and included a set of priority actions for each element of the global strategy and plan of action to address current needs in research and development, and access to medicines. Such priority actions needed to be specific and feasible with established indicators and deliverables that could be monitored.
4. The review panel took the view that the recommendations should be directed to the WHO Secretariat and/or Member States, rather than the multiplicity of relevant stakeholders. Although the contribution of stakeholders is integral to the success of the global strategy and plan of action, it is the role of the WHO Secretariat and Member States to encourage their appropriate involvement.
5. Member States and other key stakeholders should be fully engaged in the implementation of the global strategy and plan of action at an early planning stage. A mechanism for effective governance of the global strategy and plan of action is also required, as well as relevant capacity and tools for implementation and monitoring. A communications strategy and materials should be produced by the

¹ See decision WHA71(9)

² Decision EB140(8) (2017); and document EB140/2017/REC/1, Annex 6, paragraph 1(e).

WHO Secretariat to raise awareness of the global strategy and plan of action among Member States and other stakeholders.

6. On that basis, the review panel made the following proposals for priority actions between 2018 and 2022. High-priority actions are underlined. The dates proposed for achievement of the actions are indicative.

RECOMMENDATIONS

Prioritize research and development needs

1. Member States to establish sustainable financing for the Global Observatory on Health Research and Development and the Expert Committee on Health Research and Development. (*Indicator: Funding secured by 2019 to cover the projected budget up to 2022.*)
2. The WHO Secretariat to formulate a methodology for the prioritization of research and development needs for Type II and Type III diseases and the specific research and development needs of developing countries for Type I diseases for use by the Expert Committee on Health Research and Development and by Member States, to enable them to identify, respectively, both global and national research and development priorities. (*Indicator: Methodology for the prioritization of research and development needs developed by 2018.*)
3. Report by the Expert Committee on Health Research and Development identifying health research and development priorities to address unmet medical needs based on evidence from the Global Observatory on Health Research and Development and on information provided by experts and relevant stakeholders. (*Indicator: List of prioritized research and development needs for Type II and Type III diseases established by 2019, with a final list including Type I diseases established by 2020.*)

Promote research and development

4. Member States to support the WHO Secretariat in promoting transparency in, and understanding of, the costs of research and development. (*Indicator: Reports on the costs of research and development for health products prepared in 2019 and 2021.*)
5. The WHO Secretariat to establish an information-sharing mechanism to promote collaboration and coordination in research and development linked to the Expert Committee on Health Research and Development and the Global Observatory on Health Research and Development. (*Indicator: Establishment of an information-sharing mechanism to improve collaboration and coordination of resource allocation in accordance with research and development priorities by 2020.*)
6. Member States to promote programmes for collaboration with (and provision of support to) developing countries to strengthen clinical trial capacity and expert networks regionally and, where relevant, nationally. (*Indicator: Report on mapping of programmes for strengthening clinical trial capacity and expert networks regionally and nationally by 2021.*)
7. Member States and the WHO Secretariat to encourage funders of research and development to make all resulting publications open access immediately or, at the most, within six months after publication. (*Indicator: Report by 2022 on new initiatives by funders of research and*

development to ensure that the resulting publications in peer-reviewed journals are open access.)

Build and improve research capacity

8. The WHO Secretariat and Member States to develop and support collaboration programmes between internationally recognized centres for research and development and relevant institutions in developing countries to enable those countries to enhance their capacity across the research and development pipeline. *(Indicator: Report on new collaboration programmes developed and supported by 2021.)*
9. The WHO Secretariat to continue providing support to strengthen the capacity of national and regional regulatory functions and systems, including for improving clinical trial regulatory review and oversight. *(Indicator: Report on national and regional initiatives for strengthening clinical trial regulatory capacity in developing countries by 2019 and 2021.)*
10. The WHO Secretariat, in collaboration with Member States, to construct and promote the use of a database of relevant training programmes and materials for scientists and other experts involved in research and development from the public and private sectors in developing countries. *(Indicator: Database of relevant training programmes and materials established and populated and its use promoted by 2021.)*
11. Member States to promote the availability of training courses of certified quality, including online courses, for personnel involved in research and development. *(Indicator: Monitoring the availability of certified quality training courses on research and development.)*
12. Member States, with the support of the WHO Secretariat, to develop strategies and strengthen their capacity for policy formulation, regulation, research methodology and ethics, and resource preservation in traditional medicine in line with the WHO traditional medicine strategy: 2014–2023. *(Indicator: Report on national and regional programmes for developing strategies and strengthening capacity in research and development for traditional medicine by 2022.)*

Promote transfer of technology

13. The WHO Secretariat to identify mechanisms to increase health technology transfer in the context of the Technology Facilitation Mechanism established by the Sustainable Development Goals. *(Indicator: Report on the identification of mechanisms to increase health technology transfer in the context of activities related to the Technology Facilitation Mechanism by 2020.)*
14. The WHO Secretariat to work with the secretariat of WTO to identify how Article 66(2) of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) could be implemented more effectively in relation to health technology transfer in countries. *(Indicator: Report on progress on health technology transfer related to implementation of Article 66(2) of the TRIPS Agreement by 2021.)*
15. The WHO Secretariat to identify new opportunities for collaboration with other United Nations organizations (e.g. UNIDO, UNCTAD) to promote technology transfer as part of local health technology production programmes in developing countries in line with country needs. *(Indicator: Inter-organizational report on national technology transfer programmes developed and disseminated by 2022.)*

Manage intellectual property to contribute to innovation and public health

16. The WHO Secretariat, in collaboration with other international organizations working in intellectual property, to advocate for the development of national legislation to fully reflect the flexibilities provided in the TRIPS Agreement, including those recognized in the Doha Declaration on the TRIPS Agreement and Public Health and in Articles 27, 30 (including the research exception and “Bolar” provision), 31 and 31bis of the TRIPS Agreement. (*Indicator: Inter-organizational report on national legislation and patenting guidelines that include the flexibilities provided in the TRIPS Agreement prepared by 2021.*)
17. The WHO Secretariat, in collaboration with partners, to promote the further development of databases of patents and non-confidential licence agreements for health products and facilitate greater access to such databases. (*Indicator: Monitor coverage and use of existing and new databases of patent and licence information.*)
18. Member States and other funders, with WHO Secretariat support, to strengthen the Medicines Patent Pool, which may include support for the expansion of its portfolio to cover other diseases or technologies where the Medicines Patent Pool model can have the most impact. (*Indicator: Number of diseases and/or technologies covered by the Medicines Patent Pool’s portfolio and amount of funding committed by new donors by 2020.*)
19. Member States, when negotiating trade agreements, to take into account the impact on public health of adopting provisions that go beyond the requirements of the TRIPS Agreement. (*Indicator: Assessment by 2022 of evidence that negotiators of new trade agreements have taken account of the public health impact of the adoption of such agreements.*)

Improve delivery and access

20. The WHO Secretariat to develop and share good practices on evidence-based selection and health technology assessment for health products for national use, and support bilateral and regional collaboration between countries. (*Indicator: Good practices on evidence-based selection and health technology assessment developed and disseminated by 2019. Report on bilateral and regional collaboration programmes prepared by WHO by 2022.*)
21. The WHO Secretariat to provide guidance to Member States on promoting and monitoring transparency in medicine prices and on implementation of pricing and reimbursement policies. (*Indicator: Guidance developed and disseminated in countries by 2020.*)
22. The WHO Secretariat, in cooperation with Member States and other partners, to establish mechanisms to monitor patient out-of-pocket expenditure on health products. (*Indicator: Monitoring patient out-of-pocket expenditure on health products.*)
23. The WHO Secretariat to continue to support Member States in strengthening national regulatory capacity, regional harmonization and other collaborative initiatives for improving access to new and existing quality-assured medicines and health products. (*Indicator: Report on progress of national and regional regulatory capacity-building efforts in developing countries by 2021.*)
24. Member States and funders to support the WHO Prequalification of Medicines Programme to include newer essential health products, encompassing medicines, vaccines, diagnostics or biologicals. (*Indicator: Number of newer health products included in the portfolio of the Prequalification of Medicines Programme by 2020 and 2022.*)

25. The WHO Secretariat to develop best practices and implement capacity-building programmes for more appropriate use of new and existing medicines and health products in national clinical practice. (*Indicator: Best practices developed and capacity-building programmes implemented in countries by 2021.*)
26. The WHO Secretariat to promote best practices in countries and regional institutions to improve procurement and supply chain efficiency, including for joint procurement. (*Indicator: Assessment of national and regional initiatives for promoting good practices to improve procurement and supply chain efficiency by 2022.*)
27. Member States to identify essential medicines that are at risk of being in short supply and mechanisms to avoid shortages, and disseminate related information accordingly. (*Indicator: Lists of medicines at risk of being in short supply and information on mechanisms for preventing shortages made available and disseminated by 2020.*)

Promote sustainable financing mechanisms

28. Member States to commit to dedicating at least 0.01% of their gross domestic product to basic and applied research relevant to the health needs of developing countries. (*Indicator: Percentage of gross domestic product dedicated to basic and applied research as reported by G-Finder by 2021.*)
29. Member States to commit to increasing domestic resource mobilization and supporting the Addis Tax Initiative in order to, inter alia, implement the health-related Sustainable Development Goals. (*Indicator: Data from Member States on domestic resource mobilization gathered by 2021.*)
30. Member States to encourage the implementation of schemes which partially or wholly delink product prices from research and development costs, including actions recommended by the Consultative Expert Working Group on Research and Development: Financing and Coordination. (*Indicator: New schemes to partially or wholly delink product prices from research and development costs developed, approved and implemented by 2022.*)
31. Member States, with the WHO Secretariat's support, to encourage an increase and diversification of funding for product development partnerships. (*Indicator: increased and diversified funding for product development partnerships and progress as reported by G-Finder by 2022.*)

Establish a monitoring and accountability mechanism

32. The WHO Secretariat to draw up a detailed implementation plan and establish a mechanism to support implementation and monitoring of the global strategy and plan of action. (*Indicator: Implementation plan published and a mechanism for implementation and monitoring of the global strategy and plan of action established in 2018 and progress reports published at least once a year.*)
33. Member States to commit to providing information to G-Finder. (*Indicator: Number of countries that have provided information to G-Finder.*)
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ANNEX 6

Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits¹

[A71/24 – 5 April 2018]

[Paragraphs 1–18 described the progress in implementing decision WHA70(10) (2017) on Review of the Pandemic Influenza Preparedness Framework.]

Recommendations on further action

19. As requested in paragraph 8(g) of the decision, the Director-General makes the following recommendations for further action:

(a) **Paragraph 8(a)**

Subject to completion of the analysis as specified in paragraph 8(b) below, the Secretariat aims to implement measures to complete all actions within its mandate before the Seventy-second World Health Assembly.

(b) **Paragraph 8(b)**

The Secretariat intends to complete the analysis in order to submit a comprehensive draft to the Seventy-second World Health Assembly through the Executive Board at its 144th session. The draft will reflect broad input from Member States and relevant stakeholders, notably the PIP Advisory Group and representatives of the Global Influenza Surveillance and Response System. Pursuant to the decisions of the Seventy-second World Health Assembly and any further work so entailed, a final text of the analysis will be submitted to the Seventy-third World Health Assembly through the Executive Board at its 146th session.

(c) **Paragraphs 8(c), (d) and (f)**

The Secretariat will continue to strengthen critical pandemic preparedness through, inter alia:

(i) implementation of the high-level Partnership Contribution Implementation Plan 2018–2023, which will support strengthening of laboratory, surveillance and regulatory capacities as well as burden-of-disease studies;

(ii) conclusion of more Standard Material Transfer Agreements 2;

¹ See decision WHA71(11).

(iii) regular engagement with the secretariats of the Convention on Biological Diversity and other relevant international organizations that are involved in implementation of access and benefit-sharing mechanisms;

(iv) reporting on the foregoing by the Director-General to Seventy-second World Health Assembly through the Executive Board at its 144th session.

(d) **Paragraph 8(e)**

The Secretariat will take measures to implement the recommendations of the External Auditor and report thereon to the Seventy-second World Health Assembly through the Executive Board at its 144th session.

ANNEX 7

Five-year Global Strategic Plan to Improve Public Health Preparedness and Response, 2018–2023¹

[A71/8, Annex – 11 April 2018]

1. The five-year global strategic plan is based on the following guiding principles: consultation; country ownership and leadership; WHO's leadership and governance; broad partnerships; intersectoral approach; integration with the health system; community involvement; focus on countries with greatest risk of emergencies and outbreaks; regional integration; domestic financing; linking the five-year global strategic plan with requirements under the International Health Regulations (2005); and focus on results, including monitoring and accountability (see Appendix 1 for more details). It is also aligned with the definitions contained in Article 1 of the International Health Regulations (2005).

2. The strategic plan presents the Organization's approach to strengthening Member States' ability to implement the core capacities required under the International Health Regulations (2005) as a legally binding obligation and the means to ensure national and global preparedness and response to public health events, including emergencies. It builds on and is aligned with existing global instruments (for instance, WHO's global action plan on antimicrobial resistance,² the Research & Development Blueprint for action to prevent epidemics,³ and the Pandemic Influenza Preparedness framework⁴) and regional approaches, networks and mechanisms for health emergency preparedness and response, such as the Sustainable Health Agenda for the Americas 2018–2030,⁵ the Regional Strategy for Health Security and Emergencies 2016–2020 for the African Region,⁶ the Asia Pacific Strategy for Emerging Diseases⁷ – a

¹ See decision WHA71(15).

² WHO. Global action plan on antimicrobial resistance. Geneva: World Health Organization; 2015 (<http://www.who.int/antimicrobial-resistance/publications/global-action-plan/en/>, accessed 2 March 2018).

³ WHO. An R&D Blueprint for action to prevent epidemics. Geneva: World Health Organization; 2016 (<http://www.who.int/blueprint/en/>, accessed 2 March 2018).

⁴ WHO. Pandemic influenza preparedness framework for the sharing of influenza viruses and access to vaccines and other benefits. Geneva: World Health Organization; 2011 (<http://www.who.int/influenza/pip/en/>, accessed 2 March 2018).

⁵ WHO/PAHO. Sustainable health agenda for the Americas 2018–2030: a call to action for health and well-being in the Region (http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=41946&Itemid=270&lang=en, accessed 2 March 2018), approved by the 29th Pan American Sanitary Conference in resolution CSP29.R2 (http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=42290&Itemid=270&lang=en, accessed 2 March 2018).

⁶ WHO Regional Office for Africa. Regional Strategy for Health Security and Emergencies 2016–2020 (<http://afro.who.int/sites/default/files/2017-07/afr-rc66-6-en-2107.pdf>, accessed 2 March 2018).

⁷ WHO. Asia Pacific Strategy for Emerging Diseases and Public Health Emergencies (APSED III): Advancing implementation of the International Health Regulations (2005). Manila: World Health Organization Regional Office for the Western Pacific; 2017 (<http://apps.who.int/iris/bitstream/10665/259094/1/9789290618171-eng.pdf>, accessed 2 March 2018).

common strategic framework for the regions of South-East Asia and the Western Pacific, Health 2020¹ – a policy framework for the European Region, the independent Regional Assessment Commission established by the Regional Committee for the Eastern Mediterranean,² and other regional approaches.

3. The Secretariat's activities related to the implementation of the five-year strategic plan are part of the core work of the WHO Health Emergencies Programme, and as such will be covered by the overarching biennial planning and budgeting process of that Programme and as indicated in the Thirteenth General Programme of Work, 2019–2023.³

GOAL AND OBJECTIVES

4. The goal of the five-year global strategic plan is to strengthen the capacities of both the Secretariat and Member States to ensure implementation of the International Health Regulations (2005), thereby continuously improving public health preparedness and response.

5. The pillars and objectives of the strategic plan are as follows:

Pillar 1. Building and maintaining States Parties' core capacities required under the International Health Regulations (2005)

The objectives under this pillar are:

- to prioritize the Secretariat's provision of support to high-vulnerability, low-capacity countries;
- to mobilize financial resources to facilitate the implementation of the Regulations at the global, regional and national levels;
- to link the building of core capacities under the Regulations with health systems strengthening.

Pillar 2. Strengthening event management and compliance with the requirements under the International Health Regulations (2005)

The objectives under this pillar are:

- to strengthen the capacity of the Secretariat for event-based surveillance and for event management and response;
- to support and further strengthen the National IHR Focal Points;
- to improve States Parties' compliance with requirements under the Regulations;
- for the Secretariat to strengthen its technical capacity by establishing and maintaining relevant technical advisory groups of experts.

¹ WHO Regional Office for Europe. Health 2020: a European policy framework and strategy for the 21st century. Copenhagen: World Health Organization; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0011/199532/Health2020-Long.pdf?ua=1, accessed 2 March 2018).

² Resolution EM/RC62/R.3 (2015).

³ Document A71/4.

Pillar 3. Measuring progress and promoting accountability

The objectives under this pillar are:

- for the Secretariat to maintain and further strengthen its accountability through annual reporting on progress to the Health Assembly;
- for States Parties to continue to report annually to the Health Assembly on the implementation of the Regulations using the self-assessment reporting tool;
- for the Secretariat to provide technical support to regional offices and States Parties willing to use the voluntary instruments for monitoring and evaluation of implementation of the Regulations, which provide valuable additional information for the development of national action plans for health emergency preparedness.

PILLARS

Pillar 1. Building and maintaining State Parties' core capacities required under the International Health Regulations (2005)

6. The International Health Regulations (2005) are legally binding on 196 States Parties, including all 194 Member States of WHO. They were adopted by the Health Assembly in May 2005¹ and entered into force on 15 June 2007. Following the entry into force, States Parties had five years to “develop, strengthen and maintain ... the capacity to respond promptly and effectively to public health risks and public health emergencies of international concern”,² including the core capacity requirements for designated airports, ports and ground crossings, as described in Annex 1 to the Regulations. For States Parties that were not able to meet these minimum requirements in the first five years, the Regulations provided for two two-year extensions (2012–2014 and 2014–2016) to allow them time to comply.

7. In view of lessons learned from the Ebola virus disease outbreak in West Africa in 2014–2015 and other recent public health events, States Parties should focus on building and maintaining resilient health systems, and on framing core capacities as essential public health functions of their health systems. While complying with requirements to ensure mutual accountability at the international level with respect to the application and implementation of the Regulations, countries need to establish domestic monitoring and evaluation mechanisms as part of their health systems, an action that would also facilitate the monitoring of the status of core capacities, as essential public health functions.

8. Member States have overwhelmingly realized following the recent Ebola virus disease outbreak in West Africa that strong and resilient health systems underlie the good functioning of core capacities required under the Regulations. During the consultative process Member States unanimously acknowledged the vital importance of strong resilient health systems for the implementation of the Regulations, and the need to integrate the core capacities required under the Regulations with essential public health functions, within the framework of universal health coverage. They have requested the Secretariat to develop specific guidance on how countries, in particular those that face resource constraints, could be supported in building the core capacities required under the Regulations.

¹ Resolution WHA58.3 (2005).

² International Health Regulations (2005) – 3rd edition. Geneva: World Health Organization; 2016. Article 13.1.

9. A forum on universal health coverage in December 2017 – jointly organized by the World Bank, WHO, the Government of Japan, the multistakeholder platform UHC2030, UNICEF and the Japan International Cooperation Agency¹ – reaffirmed the commitment to targeted investments for preventing, detecting and responding to disease outbreaks and other emergencies, including surveillance systems, in order to safeguard health security and international collaboration under the International Health Regulations (2005) as essential public health functions of health systems. Building on the outcome of that forum and the experience of WHO regions in terms of conceptualizing, implementing and monitoring essential public health functions,² the Secretariat will develop a common framework for harmonizing the core capacities required under the International Health Regulations (2005) with the essential public health functions of health systems. This framework will further support the long-term sustainability of investments in, and planning for, resilient health systems.

10. The implications and potential gains, in terms of continuity of certain country capacities that will be triggered by the transition of the Global Polio Eradication initiative to a post-certification strategy, will have to be considered. The Seventieth World Health Assembly requested the Director-General, inter alia, “to develop a strategic action plan on polio transition by the end of 2017, to be submitted for consideration by the Seventy-first World Health Assembly, through the Executive Board at its 142nd session, that: (i) clearly identifies the capacities and assets, especially at country and, where appropriate, community levels, that are required to: sustain progress in other programmatic areas, such as: disease surveillance; immunization and health systems strengthening; early warning, emergency and outbreak response, including the strengthening and maintenance of core capacities of core capacities under the International Health Regulations (2005)”³.

11. States Parties have had more than 10 years to put in place core capacities to prevent, detect, assess, report and respond to public health risks, events and emergencies with potential to spread internationally, in accordance with the requirements of the Regulations. States Parties should continue to build and maintain these core capacities as essential public health functions of their health systems, for the effective application of the implementation of the Regulations, including those capacities related to points of entry.

12. For those States Parties whose existing national planning, financing, and monitoring and evaluation mechanisms for their health systems are suboptimal, the Secretariat will support the building and maintenance of core capacities, consistent with essential public health functions. For this purpose, the Secretariat will prepare guidance and provide technical support to Member States to develop their national action plans for health emergency preparedness, aligned with the national health sector’s strategies, plans, and essential public health functions. In their development and implementation, the national action plans should emphasize coordination of multiple relevant sectors and partners, such as the Food and Agriculture Organization and *Office International des Epizooties*, under the “One Health” approach. Financial and other sectors should be part of the planning process in order to ensure cross-sector coordination and appropriate financial allocations. The Secretariat encourages the allocation of

¹ UHC Forum 2017 (http://www.who.int/universal_health_coverage/tokyo-declaration-uhc.pdf?ua=1, accessed 19 March 2018).

² WHO Regional Office for the Eastern Mediterranean. Assessment of essential public health functions in countries of the Eastern Mediterranean Region: assessment tool. Cairo: WHO Regional Office for the Eastern Mediterranean; 2017 (<http://www.emro.who.int/about-who/public-health-functions/index.html>, accessed 2 March 2018) and Pan American Health Organization, 42nd Directing Council, document CD42/15 (2000) on essential public health functions (http://apps.who.int/iris/bitstream/10665/168476/1/cd42_15-e.pdf, accessed 2 March 2018); see also Regional Office for Europe, The 10 essential public health operations (<http://www.euro.who.int/en/health-topics/Health-systems/public-health-services/policy/the-10-essential-public-health-operations>, accessed 2 March 2018).

³ See decision WHA70(9), paragraph 9(a).

domestic financial resources to build, implement, and sustain core capacities under the Regulations within the context of existing national planning and financing mechanisms.

13. The Secretariat will work with Member States to support the development or strengthening of national action plans for health emergency preparedness, taking into account the differences between countries when it comes to governance and public health capacity. It will provide guidance and technical support in a continuum of assessment, planning, costing, implementation, monitoring and reviewing. Governments should elaborate their national action plans on the basis of the results of comprehensive country capacity assessments, with emphasis on country ownership, intersectoral coordination and strategic partnerships. Consideration will also need to be given to the role and involvement of the private sector and community and civil society organizations in the assessment, planning and implementation stages. The planning stage will build on existing country processes (for example, the “One Health” approach, initiatives to tackle antimicrobial resistance, pandemic preparedness plans, action plans to implement the 2030 Agenda for Sustainable Development, and the Sendai Framework for Disaster Risk Reduction 2015–2030¹) in order to ensure a holistic approach and avoid duplication.

14. The Secretariat will work with Member States to encourage international commitment and the allocation of domestic financial resources for the implementation of the national action plans in order to develop and maintain core capacities for surveillance and response, as agreed in the Addis Ababa Action Agenda of the Third International Conference on Financing for Development.² When gaps have been identified and areas for investment prioritized, it is crucial that Member States rapidly develop estimates of the capital and recurrent expenditures needed to bridge them. The Secretariat will develop costing and budgeting models for the national action plans, in the broader context of national health systems strengthening. It will support efforts at the national level to strengthen institutional mechanisms for coordinating international cooperation, based on the principles of effective development cooperation (country ownership, focus on results, inclusive partnerships, transparency and accountability³).

15. The Secretariat will further strengthen the operational links between its work on health systems strengthening and the WHO Health Emergencies Programme, paying particular attention to ensuring a coordinated programme of work in the development of national action plans and in the implementation of capacity-building activities in the areas of human resources for health, health planning (including monitoring and evaluation), health financing and health system resilience. Such stronger links will have a beneficial impact on health security, through the development of core capacities under the International Health Regulations (2005), and on universal health coverage, contributing thus to the attainment of the Sustainable Development Goal 3 (Ensuring healthy lives and promote well-being for all at all ages).

Pillar 2. Strengthening event management and compliance with the requirements under the International Health Regulations (2005)

16. The Secretariat and States Parties should continue to fulfil their obligations under the Regulations in relation to detection, assessment, notification and reporting of and response to public health risks and events with the potential for international spread. The functioning of the National IHR Focal Points will have to be strengthened, for instance through the provision of technical guidance, standard operating procedures, training, information sharing and lessons-learned activities.

¹ Sendai Framework for Disaster Risk Reduction 2015–2030 (<http://www.unisdr.org/we/inform/publications/43291> (accessed 2 March 2018)).

² United Nations General Assembly resolution 69/313 (2015).

³ Global Partnership for Effective Development Co-operation – principles (<http://effectivecooperation.org/about/principles/>, accessed 2 March 2018).

17. The Secretariat will continue to strengthen the global network of National IHR Focal Points, by outlining strategies to stimulate investment, trust-building, country ownership, and capacity-building, as well as strategies to strengthen communication and information sharing among them. The Secretariat will accelerate action to build the capacity of National IHR Focal Points to implement the Regulations, including calling for them to play a more prominent part in the broader national public administration, within and beyond the health sector. In addition, it will accelerate the development or revision of standard operating procedures for, and guidelines on the role of, National IHR Focal Points, and make recommendations on ways to endow them with adequate resources and to give them the authority to fulfil their obligations. These objectives will be achieved for instance through training and community-of-practice-related activities led by the Secretariat, and the enactment of appropriate national legislation with respect to the functions of National IHR Focal Points. The Secretariat will maintain a strong network of National IHR Focal Points by holding regular regional and global meetings to build capacity and share lessons learned. The content of training courses and their accessibility will be expanded through the Health Security Learning Platform in the context of the Regulations;¹ activities will include e-learning and real-time, multicountry exercises.

18. The Secretariat and States Parties will strengthen their functions and capacities for event management and response. National public health emergency operation centres need to be supported with adequate human and other resources, as part of national public health preparedness and response plans. The Secretariat will continue to work with partners in the network of emergency operations centres (EOC-NET) in developing evidence-based guidance for building, operating and improving public health emergency operations centres. The Global Outbreak Alert and Response Network will further strengthen its support to WHO and to the building of global capacity for surveillance, risk assessment, rapid international coordination of investigations and timely response.

19. The Secretariat will continue to maintain and strengthen the use of event management initiatives already in use, such as the Event Information Site for the National IHR Focal Points, regional alerts and reports, bilateral exchanges, and other communication pathways related to the Regulations, as well as linkages with valuable information sites such as the International Network of Food Safety Authorities (INFOSAN) and the Ports, Airports and Ground Crossing Network (PAG-Net). The Secretariat will strengthen its functions for event-based surveillance through the newly developed Epidemic Intelligence from Open Sources platform for early detection and risk assessment of public health events.

20. The Epidemic Intelligence from Open Sources initiative is a network of organizations with one common goal: the reduction of global morbidity and mortality through early warning for rapid response. It is both a network of experts and the source of a suite of efficient tools and platforms to support it. When launched, the platform will offer access to data from more than 6500 sources in multiple languages, including government and official sites, specific social media, news aggregators and expert groups (more than one million articles per week). The platform will collect, aggregate, deduplicate, categorize and disseminate information to end users. Access to the platform will be made gradually available to national public health institutions in Member States but the aim of the platform is not to be a reporting tool for formal notifications under the Regulations. It will contribute to the development of an integrated global alert and response system for public health emergencies, fulfilling core capacity requirements under the Regulations.

21. The Secretariat will strengthen its role in administering the existing expert advisory groups established to support the application and implementation of and compliance with the Regulations, that is, the roster of experts for the emergency and review committees, the Scientific and Technical Advisory

¹ Health Security Learning Platform in the context of the IHR (<https://extranet.who.int/hslp/training/>) (accessed 2 March 2018).

Group on geographical yellow fever risk mapping, and the WHO Ad-hoc Advisory Group on aircraft disinsection for controlling the international spread of vector-borne diseases. Experts for technical advisory groups will be selected in accordance with the Regulations for Expert Advisory Panels and Committees.¹

22. A critical element for the optimal functioning of the global alert and response system is compliance by States Parties with the requirements of the Regulations in relation to additional health measures taken in response to public health risks or public health emergencies of international concern. The term “health measure” is defined in Article 1 of the Regulations.² The Secretariat, in compliance with Article 43 (Additional health measures) of the Regulations, will share with States Parties information related to additional health measures implemented by States Parties. It will systematically collect information on additional measures, and, for measures that significantly interfere with international traffic, WHO in accordance with Article 43.3 must share with other States Parties the public health rationale and the relevant scientific information provided by the States Parties implementing those measures.

23. The Secretariat will continue to collect, monitor and report on additional health measures implemented by States Parties, in collaboration with partners such as the International Civil Aviation Organization and the International Air Transport Association. In this process, the Secretariat will:

- (a) continue to post on its website the health measures required in response to specific public health risks and the temporary recommendations associated with public health emergencies of international concern;
- (b) systematically collect information on additional health measures taken by States Parties, which may interfere with international traffic, and will post all public health measures on the WHO website, including the source of information;
- (c) request States Parties to provide the public health rationale and scientific evidence for additional health measures that significantly interfere³ with international traffic under Article 43 of the Regulations, and enhance structured dialogue with States Parties implementing additional health measures that significantly interfere with international traffic under Article 43 of the Regulations, through standard operating procedures;
- (d) post, on the password-protected Event Information System website for National IHR Focal Points, the public health rationale and scientific information provided by States Parties implementing additional health measures that significantly interfere with international traffic, provided pursuant to Article 43 of the Regulations; and
- (e) report to the Health Assembly on additional health measures that significantly interfere with international traffic and have been implemented by States Parties, as part of the Director-General’s regular reporting on the application and implementation of the Regulations.

¹ Regulations for expert advisory panels and committees (<http://apps.who.int/gb/bd/PDF/bd48/basic-documents-48th-edition-en.pdf#page=127>, accessed 2 March 2018).

² Article 1 of the Regulations states that “health measure” means procedures applied to prevent the spread of disease or contamination; a health measure does not include law enforcement or security measures.

³ “Significant interference generally means refusal of entry or departure of international travellers, baggage, cargo, containers, conveyances, good and the like, or their delay, for more than 24 hours” (Article 43.3 of the International Health Regulations, (2005)).

24. WHO will maintain regular contact with the World Trade Organization to devise a mechanism to deal with trade-related issues during public health emergencies of international concern. Furthermore, the Director-General will continue to fulfil mandates related to the settlement of disputes as described in Article 56 of the Regulations.

25. The Secretariat will strengthen its work on monitoring and improving compliance of States Parties with requirements under the Regulations. Through a strategic and more systematic approach in outlining the key elements of compliance with the Regulations, the Secretariat will delineate more clearly the incentives available for States Parties to maintain compliance, and develop standard operating procedures to bring to the attention of responsible authorities instances of non-compliance. This may include increasing transparency in sharing information, peer-pressure and promoting dialogue among States Parties.

Pillar 3. Measuring progress and promoting accountability

26. An important element for global health preparedness and response is the regular monitoring of progress, both in establishing and maintaining by States Parties the core capacities defined in Annex 1 to the Regulations, and in the ability of the Secretariat to prevent and respond to the international spread of diseases and to public health risks with the potential for international spread.

27. Article 54.1 of the Regulations requires that “States Parties and the Director-General shall report to the Health Assembly on the implementation of these Regulations as decided by the Health Assembly”. Such reports shall comprise monitoring the status of core capacities defined in Annex 1 to the Regulations. The annual frequency of reporting to the Health Assembly was determined by the Sixty-first World Health Assembly in 2008.¹ Since 2010, the Secretariat has proposed a self-assessment tool, focusing on core capacities, for use by States Parties in order to fulfil their annual reporting obligation to the Health Assembly. A historical overview of monitoring implementation of the Regulations is presented in Appendix 2.

28. The Secretariat will continue to provide States Parties with the self-assessment annual reporting tool,² introduced in 2010. The Secretariat is revising the annual self-assessment reporting tool, and this revised instrument will be proposed, through the governing bodies, to States Parties for future annual reporting. The self-assessment annual reporting tool will continue to be the instrument used by States Parties to fulfil their obligations for annual reporting to the Health Assembly.

29. In compliance with resolution WHA68.5 (2015) on the recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation, including the recommendation that the Secretariat should develop options “to move from exclusive self-evaluation to approaches that combine self-evaluation, peer review and voluntary external evaluations involving a combination of domestic and independent experts”, the plan proposes three additional and voluntary instruments to complement the assessment and monitoring of core capacities under the Regulations. These instruments include voluntary joint external evaluations, simulation exercises and after-action reviews. The Secretariat has developed corresponding technical tools and will revise and adapt them in the light of experience gained. The outcomes of the different monitoring and evaluation processes inform the development of national action plans for public health preparedness and response. However, the Secretariat’s overall support to Member States for developing

¹ Resolution WHA61.2 (2008).

² International Health Regulations (2005): State Party self-assessment annual reporting tool. Geneva: World Health Organization; 2018 (document WHO/WHE/CPI/2018.16; <http://www.who.int/ihr/publications/WHO-WHE-CPI-2018.16/en/>, accessed 10 May 2018).

and implementing national action plans to improve their public health preparedness and response is not conditional on the conduct of these voluntary assessments.

30. The voluntary joint external evaluations allow Member States to further identify strengths and weaknesses within their national health systems in relation to public health emergency preparedness and response. This is done through a dialogue between national and external experts through the joint review of country self-evaluation compared with the evaluation by external experts. The selection of experts for the assessment team and the method for conducting the assessment will be agreed in advance with the country that has requested the voluntary joint assessment. A jointly agreed score is then determined. The joint external evaluation tool, developed by the Secretariat with input from external experts assesses 19 technical areas and is available on the WHO website.¹ It is being used in joint external evaluations. The tool will be reviewed on the basis of experience gained from volunteered countries.

31. Two other additional instruments have been developed by the Secretariat to support countries to assess the operational capability of their national capacity for public health preparedness and response. Use of both is voluntary and involves the participation of external experts. They include two elements: (a) simulation exercises, to test the actual functioning of alert and response elements, in particular in relation to information sharing, communication, overall coordination, capacity mobilization and response timeliness – a specific WHO guideline has been developed for simulation exercises;² and (b) after-action review, to assess the real-life response to a past public health emergency in order to draw lessons and identify opportunities for improvement. The Secretariat is finalizing an after-action review guide, which it is pilot testing in volunteer Member States.

32. The strategic plan includes deliverables and timelines for measuring progress at the global and regional levels (see Appendix 3). Most WHO regions have existing strategies and frameworks that will be taken into account in implementing and monitoring the plan.

33. In May 2016 the Director-General established the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme.³ The Committee's main functions include assessing the performance of the Programme's key functions in health emergencies; determining the appropriateness and adequacy of the Programme's financing and resourcing; providing advice to the Director-General; and reporting, through the Director-General and the Executive Board, to the Health Assembly on progress in implementing the Programme. As the five-year global strategic plan is intended to be an integral part of the WHO Health Emergencies Programme, once adopted it will also be regularly reviewed and monitored by the Independent Oversight and Advisory Committee.

34. The deliverables, timelines and indicators that comprise the framework for monitoring the progress of implementation of the five-year global strategic plan are set out in Appendix 3.

¹ WHO. IHR (2005) Monitoring and Evaluation framework: joint external evaluation tool (JEE tool); first edition. Geneva: World Health Organization; 2016 (http://who.int/ihr/publications/WHO_HSE_GCR_2016_2/en/, accessed 2 March 2018).

² WHO. WHO simulation exercise manual: a practical guide and tool for planning, conducting and evaluating simulation exercises for outbreaks and public health emergency preparedness and response. Geneva: World Health Organization; 2017, document WHO/WHE/CPI/2017.10 (<http://who.int/ihr/publications/WHO-WHE-CPI-2017.10/en/>, accessed 2 March 2018).

³ For further information see http://www.who.int/about/who_reform/emergency-capacities/oversight-committee/en/ (accessed 2 March 2018).

Appendix 1

GUIDING PRINCIPLES FOR THE FIVE-YEAR GLOBAL STRATEGIC PLAN

This Appendix presents the guiding principles contained in document A70/16 after revision in the light of comments and suggestions received during the discussions of the WHO regional committees in 2017, the subsequent web-based consultation and the meeting of Member States (Geneva, 8 November 2017). The goal of the plan is to strengthen the capacities of both the Secretariat and Member States to ensure implementation of the International Health Regulations (2005), thereby continuously improving public health preparedness and response. The guiding principles are outlined in the following table.

Table. Guiding principles for the five-year global strategic plan to improve public health preparedness and response¹

Guiding principle	Details
1. Consultation	Consultative process from May to November 2017 through the regional committees, a web-based consultation and a formal consultation of Member States, through the focal points in the Geneva-based permanent missions, followed by discussion by Member States at the 142nd session of the Executive Board and further consideration by the Seventy-first World Health Assembly in May 2018.
2. Country ownership and leadership	Building and sustaining core capacities as required under the International Health Regulations (2005) as essential public health functions of their health systems, at the national and subnational levels, are the primary responsibility of governments, taking into account their national health, social, economic, health security and political contexts.
3. WHO's leadership and governance	The WHO Health Emergencies Programme will lead the development and implementation of the five-year global strategic plan. The Director-General will report on progress to the governing bodies, as part of the regular reporting on the application and implementation of the International Health Regulations (2005).
4. Broad partnerships	Many States Parties require technical support to assess, build and maintain their core capacities required under the Regulations as essential public health functions of their health systems. Many global partners support countries in the field of health systems strengthening and public health preparedness and response. As decided by the Fifty-eighth World Health Assembly, ² WHO will cooperate and coordinate its activities, as appropriate, with the inter alia following: the United Nations, Food and Agriculture Organization, International Air Transport Association, International Atomic Energy Agency, International Civil Aviation Organization, International Labour Organization, International Maritime Organization, International Committee of the Red Cross, International Federation of Red Cross and Red Crescent Societies, International Shipping Federation and <i>Office Internationale des Epizooties</i> . WHO will also cooperate and coordinate its activities, as appropriate, with those of regional political and economic organizations (including The African Union, Association of Southeast Asian Nations, European Union, Southern

¹ Based on document A70/16, Annex 2.

² Resolution WHA58.3 (2005).

Guiding principle	Details
	African Development Community and the Pacific Community). Cooperation with other relevant non-State actors and industry associations will also be considered, within the WHO's Framework of Engagement with Non-State Actors. ¹
5. Intersectoral approach	Responding to public health risks, events and emergencies requires a multisectoral, coordinated approach (for example, with agriculture, transport, tourism and finance sectors). Many countries already have health coordination platforms or mechanisms in place, such as the One-Health approach. The five-year global strategic plan will provide strategic orientation for the planning for public health preparedness and response across multiple sectors.
6. Integration with the health system	The Ebola virus disease outbreak in West Africa in 2014–2015 put both health security and health systems resilience high on the development agenda. Framing the core capacities detailed in Annex 1 to the International Health Regulations (2005) as essential public health functions will mutually reinforce health security and health systems, leading to resilient health systems.
7. Community involvement	Effective public health preparedness can only be achieved with the active participation of local governments, civil society organizations, local leaders, and individual citizens. Communities must take ownership of their preparedness and strengthen it for emergencies that range in scale from local or national events to pandemics and disasters.
8. Focus on countries with greatest risk of emergencies and outbreaks	The WHO Health Emergencies Programme is supporting all countries in their preparedness and response efforts in relation to public health risks, events and emergencies, but its initial focus will be on a set of countries that have been identified by the Programme to be in vulnerable situations. The Secretariat's support to countries for health emergency preparedness will be aligned with the priorities identified by the Thirteenth General Programme of Work 2019–2023. ²
9. Regional integration	Building on the five-year global strategic plan, the regional offices will consider the development of regional operational plans, taking into account the respective roles of the three levels of WHO, and the existing regional frameworks and mechanisms, such as: the Sustainable Health Agenda for the Americas 2018–2030 – a strategic call to action for health and well-being in the Region, ³ the Regional Strategy for Health Security and Emergencies 2016–2020 – a strategy adopted by the Regional Committee for Africa; ⁴ the Asia Pacific Strategy for Emerging Diseases and Public Health Emergencies – a common strategic framework for the regions of South-East Asia and the Western Pacific; ⁵ Health 2020 – a policy framework and strategy for the European Region; ⁶ the Regional Assessment Commission on the status of implementation of the International Health Regulations (2005) established by the Regional

¹ WHO's Framework of Engagement with Non-State Actors, adopted in resolution WHA69.10 (2016) (http://www.who.int/about/collaborations/non-state-actors/A69_R10-FENSA-en.pdf?ua=1, accessed 2 March 2018).

² Document A71/4.

³ Adopted in resolution CSP29.R2 (2017).

⁴ Adopted in resolution AFR/RC66/R3 (2016).

⁵ Adopted in resolution WPR/RC67.R6 (2016).

⁶ Adopted in resolution EUR/RC62/R4 (2012).

Guiding principle	Details
	Committee for the Eastern Mediterranean, ¹ and other regional approaches, and emphasizing collective approaches to achieve the core capacities required under the Regulations.
10. Domestic financing	For long-term sustainability, the budgeting and financing of core capacities required under the Regulations as essential public health functions should be supported to the extent possible from domestic resources. The Secretariat will work with Member States to encourage the allocation of domestic financial resources to build and sustain essential public health functions within the context of existing national planning and financing mechanisms. In Member States that require substantial external resources, the Secretariat will provide support for strengthening the institutional mechanisms for coordinating international cooperation, based on the principles of effective development cooperation (country ownership, focus on results, inclusive partnerships, transparency and accountability). ²
11. Linking the five-year global strategic plan with requirements under the International Health Regulations (2005)	The five-year global strategic plan proposes strategic directions in relation to the relevant requirements under the Regulations for States Parties and for the Secretariat, as well as voluntary operational and technical aspects that are not a requirement under the Regulations.
12. Focus on results, including monitoring and accountability	The five-year global strategic plan has its own monitoring framework, including indicators and timelines. Indicators for monitoring implementation of the strategic plan are presented in Appendix 3.

¹ Resolution EM/RC62/R.3 (2015).

² Global Partnership for Effective Development Co-operation – principles (<http://effectivecooperation.org/about/principles/>, accessed 2 March 2018).

Appendix 2

**HISTORICAL OVERVIEW OF MONITORING PROGRESS IN THE
IMPLEMENTATION OF THE INTERNATIONAL HEALTH
REGULATIONS (2005)**

1. Article 54.1 of the Regulations requires that “States Parties and the Director-General shall report to the Health Assembly on the implementation of these Regulations as decided by the Health Assembly”; this requirement implicitly also covers monitoring the status of core capacities. In 2008, the Health Assembly, through resolution WHA61.2, decided that “States Parties and the Director-General shall report to the Health Assembly on the implementation of the Regulations annually”. The Health Assembly also requested the Director-General “to submit every year a single report, including information provided by States Parties and about the Secretariat’s activities, to the Health Assembly for its consideration”. In 2008 and 2009, a questionnaire was sent by the Secretariat to States Parties, focused mainly on self-reported processes related to the establishment and functioning of the National IHR Focal Points.¹

2. In 2010, the Secretariat developed and shared with States Parties a core capacity monitoring framework,² with a questionnaire on the status of implementation of the Regulations for States Parties to complete on a voluntary basis. This framework included a checklist and 20 indicators on the status of eight core capacities, capacities at points of entry, and four specific hazards covered by the Regulations, namely biological (zoonotic diseases, food safety events and other infectious hazards), chemical, radiological and nuclear events. The self-assessment tool, completed and submitted by States Parties to the Secretariat on an annual basis (from 2010 to 2017), constituted the basis for compiling the report on the implementation of the Regulations by the Secretariat to the Health Assembly. States Parties’ specific scores related to the status of each core capacity were included in the Secretariat’s annual implementation report to the Health Assembly from 2013 to 2015.³ From 2015, these scores were made available online through the Global Health Observatory.⁴

In 2015, the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation recommended that the Secretariat develop “options to move from exclusive self-evaluation to approaches that combine self-evaluation, peer review and voluntary external evaluations involving a combination of domestic and independent experts”.⁵ In resolution WHA68.5 (2015) the Health Assembly urged Member States to support the implementation of the recommendations of the Review Committee and requested the Director-General to present an update to the Sixty-ninth World Health Assembly on progress made in taking forward those recommendations. The Secretariat then developed a concept note outlining a new approach for monitoring and evaluation of the core capacities required by the Regulations.⁶ The concept note was discussed by the WHO regional committees in 2015, and a revised monitoring and evaluation framework was submitted to, and noted by, the Sixty-ninth World Health Assembly in 2016.

¹ See documents A62/6 and A63/5.

² IHR core capacity monitoring framework: checklist and indicators for monitoring progress in the development of IHR core capacities in States Parties. Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/10665/84933/1/WHO_HSE_GCR_2013.2_eng.pdf?ua=1, accessed 2 March 2018).

³ Documents A64/9, A65/17, A66/16, A66/16 Add.1, A67/35, A67/35 Add.1 and A68/22.

⁴ Global Health Observatory data: International Health Regulations (2005) monitoring framework (<http://www.who.int/gho/ihr>, accessed 2 March 2018).

⁵ See document WHA68/2015/REC/1, Annex 2.

⁶ Development, monitoring and evaluation of functional core capacity for implementing the International Health Regulations (2005): concept note (http://www.who.int/ihr/publications/concept_note_201507/en/, accessed 2 March 2018).

Appendix 3

**DELIVERABLES, TIMELINES AND INDICATORS TO MONITOR THE IMPLEMENTATION
OF THE FIVE-YEAR GLOBAL STRATEGIC PLAN, 2018–2023**

Pillars and objectives of the five-year global strategic plan	Deliverables and timelines	Indicators
<p>Pillar 1. Building and maintaining State Parties' core capacities required under the International Health Regulations (2005)</p> <ul style="list-style-type: none"> • Prioritize the Secretariat's provision of support to high-vulnerability, low-capacity countries • Mobilize financial resources to facilitate the implementation of the Regulations at the global, regional and national levels • Link the building of core capacities under the Regulations with health systems strengthening 	<ul style="list-style-type: none"> • Conceptual framework for harmonizing the core capacities requirements under the Regulations with national health systems and essential public health functions developed by May 2018, building on the outcome of the universal health coverage forum held at the end of 2017 • WHO's Strategic Partnership Portal regularly updated to map progress and available resources • Guidance for preparedness for cross-border activities 	<ul style="list-style-type: none"> • Number of countries supported annually in the development or updating of their national action plans for health emergency preparedness
<p>Pillar 2. Strengthening event management and compliance with the requirements under the International Health Regulations (2005)</p> <ul style="list-style-type: none"> • Strengthen the capacity of the Secretariat for event-based surveillance and for event management and response • Support and further strengthen the National IHR Focal Points • Improve States Parties' compliance with requirements under the Regulations 	<ul style="list-style-type: none"> • Epidemic intelligence from open sources platform for early detection and risk assessment of public health events developed by March 2018 and updated annually • Coordination procedures in place and implemented with partners in the Global Outbreak and Alert Response Network for assessments, response planning and deployment of support to countries for any event of potential international concern • Strategy for strengthening National IHR Focal Points developed by October 2018 	<ul style="list-style-type: none"> • Average time between an event occurring and being reported • Number of partners in the Global Outbreak and Alert Response Network mobilized annually for emergency response • Number of outbreak response training courses conducted by the Global Outbreak and Alert Response Network annually • Go.Data tool for management of contact tracing and visualization of chains of transmission designed and developed by June 2018

Pillars and objectives of the five-year global strategic plan	Deliverables and timelines	Indicators
<ul style="list-style-type: none"> The Secretariat to strengthen its technical capacity by establishing and maintaining relevant technical advisory groups of experts 	<ul style="list-style-type: none"> Strategic approach/mechanism for monitoring and improving compliance of States Parties with requirements under the Regulations established by the Secretariat by June 2018, and reviewed annually WHO's standard operating procedures for following-up on additional health measures and raising cases of concern to the appropriate national authority drafted by February 2018 and communicated to States Parties, and used systematically in case of public health emergencies Web-based repository of WHO health measures for public health risks and temporary recommendations for public health emergencies of international concern regularly maintained and updated The Director-General's annual progress report on the implementation of the International Health Regulations (2005) to contain information on the additional health measures implemented by States Parties under Article 43 of the Regulations, starting from 2018 	<ul style="list-style-type: none"> Number of National IHR Focal Points participating annually in regional and global capacity strengthening activities Number of modules on implementation of the Regulations on the Health Security Learning Platform for National IHR Focal Points developed and used annually Number of International Health Regulations Emergency Committees called Percentage of States Parties having designated a State-nominated expert to the IHR Expert Roster Number of countries having implemented additional health measures not in compliance with Article 43 of the Regulations Repository of information on State Parties' rationale and scientific information on additional health measures that significantly interfere with international traffic regularly accessible on the Event Information System on the WHO website, and reviewed annually Number of meetings of the technical expert advisory groups held annually

<p>Pillars and objectives of the five-year global strategic plan</p>	<p>Deliverables and timelines</p>	<p>Indicators</p>
<p>Pillar 3. Measuring progress and promoting accountability</p> <ul style="list-style-type: none"> • The Secretariat to maintain and further strengthen its accountability through regular reporting on progress to the Health Assembly • States Parties to continue to report annually to the Health Assembly on the implementation of the Regulations, using the self-assessment reporting tool • For the Secretariat to provide technical support to regional offices and Member States willing to use the voluntary instruments for monitoring and evaluation of implementation of the Regulations 	<ul style="list-style-type: none"> • Revised self-assessment annual reporting tool proposed to States Parties by June 2018 • Annual self-assessment reporting tool used by States Parties for reporting annually on the status of implementation of the Regulations • Report on progress on implementation of the five-year global strategic plan submitted to the Health Assembly annually, starting from 2019, as part of the annual progress report to the Health Assembly on implementation of the International Health Regulations (2005) 	<ul style="list-style-type: none"> • Number of countries that improve their year-to-year scores on core capacities under the Regulations • Number of countries supported by the Secretariat annually for the evaluation of their capacities through the voluntary monitoring and evaluation instruments

ANNEX 8

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

Resolution WHA71.2 Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018	
A. Link to the programme budget	
1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.	<p>Programme area: 2. Noncommunicable diseases</p> <p>Outcome: 2.1. Increased access to interventions to prevent and manage noncommunicable diseases and their risk factors</p> <p>Outputs:</p> <p>2.1.1. Development and implementation of national multisectoral policies and plans to prevent and control noncommunicable diseases accelerated</p> <p>2.1.2. Countries enabled to implement strategies to reduce modifiable risk factors for noncommunicable diseases (tobacco use, diet, physical inactivity and harmful use of alcohol), including the underlying social determinants</p> <p>2.1.3. Countries enabled to improve health care coverage for the management of cardiovascular diseases, cancer, diabetes and chronic respiratory diseases and their risk factors, including in crises and emergencies</p>
2. Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.	Not applicable.
3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.	Not applicable.
4. Estimated implementation time frame (in years or months) to achieve the resolution.	Eight years: all activities referred to in the resolution will be carried out during the bienniums 2020–2021, 2022–2023 and 2024–2025.
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	US\$ 179 million (2018–2019).
2.a. Estimated resource requirements already planned for in the Programme budget 2018–2019, in US\$ millions:	US\$ 179 million was planned for in the Programme budget 2018–2019: thus there are no additional requirements.
2.b. Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US\$ millions:	Not applicable.

3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:
Same as those in the Programme budget 2018–2019.
4. Estimated resource requirements in future programme budgets, in US\$ millions:
Programme budget 2022–2023: same as those in the Programme budget 2018–2019. Programme budget 2024–2025: same as those in the Programme budget 2018–2019.
5. Resources available 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\$ 82 million (46% of US\$ 179 million). – Remaining financing gap in the current biennium: US\$ 97 million (US\$ 179 million minus US\$ 82 million). – Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium: US\$ 97 million.

Resolution WHA71.3 Preparation for a high-level meeting of the General Assembly on ending tuberculosis
A. Link to the programme budget
<p>1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.</p> <p>Programme area: 1.2. Tuberculosis</p> <p>Outcome: 1.2. Universal access to quality tuberculosis care in line with the End TB Strategy</p> <p>Output(s):</p> <p>1.2.1. Worldwide adaptation and implementation of the End TB Strategy and targets for tuberculosis prevention, care and control after 2015, as adopted in resolution WHA67.1</p> <p>1.2.2. Updated policy guidelines and technical tools to support the implementation of the End TB Strategy and efforts to meet targets for tuberculosis prevention, care and control after 2015, covering the three pillars: (1) integrated, patient-centred care and prevention; (2) bold policies and supportive systems; and (3) intensified research and innovation</p>
<p>2. Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.</p> <p>Not applicable.</p>
<p>3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.</p> <p>Work called for within the resolution is already addressed in the Programme budget 2018–2019, including normative and strategic guidance, technical cooperation, monitoring and evaluation, research strategy and promotion efforts, as well as coordination efforts with other organizations of the United Nations system and other stakeholders. The expectation is that within the available budget, further stakeholder consultations can be held and technical cooperation undertaken to advance efforts including strengthened accountability of all stakeholders – governmental and non-State actors – at the country, regional and global levels.</p>
<p>4. Estimated implementation time frame (in years or months) to achieve the resolution.</p> <p>Six years (2018–2023).</p>

B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	<p>For 2018–2019: US\$ 123.9 million, as in the Programme budget 2018–2019.</p> <p>For subsequent bienniums, the resource requirements will be further assessed and confirmed during the development of the relevant programme budget.</p>
2.a. Estimated resource requirements already planned for in the Programme budget 2018–2019, in US\$ millions:	<p>US\$ 123.9 million (Programme budget 2018–2019 for tuberculosis).</p>
2.b. Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US\$ millions:	<p>No additional resource requirements are expected for the current biennium.</p>
3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:	<p>The resolution calls for acceleration of work on tuberculosis, compared with current effort, and will require, as a minimum, a 4% increase in resources in the Programme budget 2018–2019. The estimates will be further assessed and confirmed during the development of the programme budget for 2020–2021.</p>
4. Estimated resource requirements in future programme budgets, in US\$ millions:	<p>It is expected that the acceleration of work on tuberculosis undertaken during 2020–2021 will be continued and will require, as a minimum, a 4% increase in resources in the Programme budget 2020–2021, to be reflected in future programme budget resource requirements.</p>
5. Resources available 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\$ 75 million. – Remaining financing gap in the current biennium: US\$ 49 million. – Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium: US\$ 30 million.

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

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	25.0	11.3	0.95	5.3	5.75	3.3	7.4	59.0
	Activities	10.7	21.1	0.95	12.5	5.75	4.9	9.0	64.9
	Total	35.7	32.4	1.9	17.8	11.5	8.2	16.4	123.9
2018–2019 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 resources to be planned	Staff	26.0	11.8	1.0	5.5	6.0	3.4	7.7	61.4
	Activities	11.1	21.9	1.0	13.0	6.0	5.1	9.4	67.5
	Total	37.1	33.7	2.0	18.5	12.0	8.5	17.1	128.9
2022–2023 resources to be planned	Staff	27.0	12.2	1.03	5.8	6.2	3.5	8.0	63.8 ^a
	Activities	11.6	22.8	1.03	13.5	6.2	5.3	9.7	70.2 ^a
	Total	38.6	35.0	2.06	19.3	12.4	8.8	17.7	134.0

^a The row total does not add up due to rounding.

Resolution WHA71.4 Cholera prevention and control	
A. Link to the programme budget	
1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.	<p>Programme area: E.1. Infectious hazard management</p> <p>Outcome: E.1. All countries are equipped to mitigate risks from high-threat infectious hazards.</p> <p>Output: E.1.1. Control strategies, plans and capacities developed for diseases such as cholera, viral haemorrhagic fever, meningitis and influenza and those due to vector-borne, emerging and re-emerging pathogens.</p>
2. Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.	Not applicable.
3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.	In line with the proposed resolution, additional activities for the biennium 2018–2019 include the reinforcement of the Global Task force on Cholera Control secretariat at WHO through the recruitment of additional staff, and increased capacity to support countries to scale up their ability to implement and monitor multisectoral cholera control plans through the organization of in-country workshops and recruitment of technical experts to be based in at least four cholera-affected countries.
4. Estimated implementation time frame (in years or months) to achieve the resolution.	The resolution is aligned with the time frame of the Ending cholera: a global roadmap to 2030, with objectives set to reduce cholera deaths by 90% by 2030.

B. Resource implications for the Secretariat for implementation of the resolution
<p>1. Total resource requirements to implement the resolution, in US\$ millions:</p> <p>Estimated at US\$ 121 million from 2018 to 2030, with an expected increase in staffing and activities in countries to provide support for the implementation of the entire road map in countries.</p>
<p>2.a. Estimated resource requirements already planned for in the Programme budget 2018–2019, in US\$ millions:</p> <p>US\$ 7.93 million.</p>
<p>2.b. Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US\$ millions:</p> <p>Zero.</p>
<p>3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:</p> <p>US\$ 19.69 million for the biennium 2020–2021.</p>
<p>4. Estimated resource requirements in future programme budgets, in US\$ millions:</p> <p>US\$ 10.43 annually, which reflects a 20% increase in staffing and activities requirements in the African Region, South-East Asia Region and Eastern Mediterranean Region, up to 2030.</p>
<p>5. Resources available to fund the implementation of the resolution in the current biennium, in US\$ millions</p> <ul style="list-style-type: none"> – Resources available to fund the resolution in the current biennium: US\$ 4.10 million available under the cholera workplan 2018–2019 of the programme budget of the WHO Health Emergencies Programme. – Remaining financing gap in the current biennium: US\$ 3.83 million. – Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium: Zero.

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

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	3.87	1.00	0.25	0.20	NA	0.40	NA	5.72
	Activities	1.06	0.79	0.00	0.18	NA	0.18	NA	2.21
	Total	4.93	1.79	0.25	0.38	NA	0.58	NA	7.93
2018–2019 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 resources to be planned	Staff	5.09	4.00	0.50	0.80	NA	1.20	NA	11.60
	Activities	1.70	3.56	0.53	0.57	NA	1.70	NA	8.09
	Total	6.79	7.56	1.03	1.37	NA	2.90	NA	19.69
Future bienniums resources to be planned	Staff	5.09	6.00	0.50	0.96	NA	1.44	NA	13.99
	Activities	1.93	2.68	0.39	0.68	NA	1.19	NA	6.87
	Total	7.02	8.68	0.89	1.64	NA	2.63	NA	20.86

NA: not applicable.

Resolution WHA71.5 Addressing the burden of snakebite envenoming	
A. Link to the programme budget	
1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.	
Programme areas:	
1.4. Neglected tropical diseases	
4.3. Access to medicines and other health technologies and strengthening regulatory capacity	
Outcome(s):	
1.4. Increased and sustained access to neglected tropical disease control interventions	
4.3. Improved access to and rational use of safe, efficacious and affordable quality medicines and other health technologies	
Output(s):	
1.4.2. Implementation and monitoring of neglected tropical disease control interventions facilitated by evidence-based technical guidelines and technical support	
4.3.1. Access to and use of essential medicines and other health technologies improved through global guidance and the development and implementation of national policies, strategies and tools	
4.3.3. Improved quality and safety of medicines and other health technologies through norms, standards and guidelines, strengthening of regulatory systems, and prequalification	
2. Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.	
Not applicable.	
3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.	
Although they were not specified during the process of preparing the Programme budget 2018–2019, the deliverables planned will contribute to the outputs detailed above. They are set out below.	
<ul style="list-style-type: none"> • Accelerate global efforts and coordination for the control of snakebite envenoming, ensuring the quality, efficacy and safety of antivenoms and other treatments, and the prioritization of high impact interventions; • Continue to offer technical support to institutions working on research into snakebite envenoming, including WHO collaborating centres, in support of improved, evidence-based disease control efforts; • Foster international efforts aimed at strengthening the production, regulation and control of quality, safety and efficacy of snake antivenom immunoglobulins and improving the availability, accessibility and affordability of safe and effective antivenoms for all; • Support Member States to strengthen capacities for improving awareness and prevention and access to treatment, and for reducing and controlling snakebite envenoming; • Foster technical cooperation among countries as a means of strengthening surveillance, treatment and rehabilitation services; • Cooperate, as appropriate and in accordance with their respective mandates, with international agencies, nongovernmental organizations, foundations and research institutions, to directly support countries in which the disease is prevalent, upon the request of such countries, in order to strengthen snakebite management activities. 	

<p>4. Estimated implementation time frame (in years or months) to achieve the resolution.</p> <p>No end-date is presently foreseen for this resolution, with implementation efforts forming part of the ongoing work concerned with the control and elimination of neglected tropical diseases. The financial information presented here concerns the six-year period July 2018 to–2023.</p>
<p>B. Resource implications for the Secretariat for implementation of the resolution</p>
<p>1. Total resource requirements to implement the resolution, in US\$ millions:</p> <p>US\$ 29.66 million for the first six years.</p>
<p>2.a Estimated resource requirements already planned for in the Programme budget 2018–2019, in US\$ millions:</p> <p>Zero.</p> <p>2.b Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US\$ millions:</p> <p>US\$ 6.33 million.</p>
<p>3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:</p> <p>US\$ 10.63 million.</p>
<p>4. Estimated resource requirements in future programme budgets, in US\$ millions:</p> <p>US\$ 12.70 million per biennium, plus cost of indexation against inflation.</p>
<p>5. Resources available to fund the implementation of the resolution in the current biennium, in US\$ millions</p> <ul style="list-style-type: none"> – Resources available to fund the resolution in the current biennium: Zero. – Remaining financing gap in the current biennium: US\$ 6.33 million. – Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium: None at present. Mobilization of funds will be linked to the primary outcome of the deliverables in the biennium 2018–2019. The development of the snakebite envenoming roadmap and the organization of the associated stakeholder meeting are expected to mobilize donor voluntary contributions amounting to at least 50% of the biennium budget.

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

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2018–2019 additional resources	Staff	1.32	0.15	0.13	0.12	0.07	0.12	0.14	2.05
	Activities	2.53	0.55	0.23	0.31	0.16	0.24	0.26	4.28
	Total	3.85	0.70	0.36	0.43	0.23	0.36	0.40	6.33
2020–2021 resources to be planned	Staff	1.98	1.04	0.69	0.83	0.33	0.63	0.70	6.20
	Activities	2.85	0.47	0.21	0.28	0.16	0.22	0.24	4.43
	Total	4.83	1.51	0.90	1.11	0.49	0.85	0.94	10.63
Future bienniums resources to be planned	Staff	3.26	1.08	0.96	0.86	0.50	0.87	0.98	8.51
	Activities	2.55	0.49	0.22	0.29	0.16	0.23	0.25	4.19
	Total	5.81	1.57	1.18	1.15	0.66	1.10	1.23	12.70

Resolution WHA71.6 WHO's global action plan on physical activity 2018–2030	
A. Link to the programme budget	
1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.	<p>Programme area: 2.1. Noncommunicable diseases</p> <p>Outcome: 2.1. Increased access to interventions to prevent and manage noncommunicable diseases and their risk factors</p> <p>Outputs:</p> <p>2.1.1. Development and implementation of national multisectoral policies and plans to prevent and control noncommunicable diseases accelerated</p> <p>2.1.2. Countries enabled to implement strategies to reduce modifiable risk factors for noncommunicable diseases (tobacco use, diet, physical inactivity and harmful use of alcohol), including the underlying social determinants</p> <p>2.1.4. Monitoring framework implemented to report on the progress made on the commitments contained in the Political Declaration of the High-Level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases and in the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020</p>
2. Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.	Not applicable.
3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.	None.
4. Estimated implementation time frame (in years or months) to achieve the resolution.	Eight years.

B. Resource implications for the Secretariat for implementation of the resolution
<p>1. Total resource requirements to implement the resolution, in US\$ millions: US\$ 30.3 million.</p>
<p>2.a Estimated resource requirements already planned for in the Programme budget 2018–2019, in US\$ millions: US\$ 9.4 million.</p>
<p>2.b Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US\$ millions: Zero.</p>
<p>3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions: US\$ 8.1 million.</p>
<p>4. Estimated resource requirements in future programme budgets, in US\$ millions: 2022–2023: US\$ 6.4 million. 2024–2025: US\$ 6.4 million.</p>
<p>5. Resources available to fund the implementation of the resolution in the current biennium, in US\$ millions</p> <ul style="list-style-type: none"> – Resources available to fund the resolution in the current biennium: Zero. – Remaining financing gap in the current biennium: US\$ 9.4 million. – Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium: Zero.

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

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	1.2	0.8	0.8	0.6	0.7	0.6	0.7	5.4
	Activities	2.8	0.2	0.2	0.2	0.2	0.2	0.2	4.0
	Total	4.0	1.0	1.0	0.8	0.9	0.8	0.9	9.4
2018–2019 additional resources	Staff	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Activities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
2020–2021 resources to be planned	Staff	1.2	0.8	0.8	0.6	0.7	0.6	0.7	5.4
	Activities	1.5	0.2	0.2	0.2	0.2	0.2	0.2	2.7
	Total	2.7	1.0	1.0	0.8	0.9	0.8	0.9	8.1
Future bienniums resources to be planned	Staff	2.4	1.6	1.6	1.2	1.4	1.2	1.4	10.8
	Activities	0.8	0.2	0.2	0.2	0.2	0.2	0.2	2.0
	Total	3.2	1.8	1.8	1.4	1.6	1.4	1.6	12.8

Resolution WHA71.7 Digital health	
A. Link to the programme budget	
1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.	
Programme areas:	
2.1. Noncommunicable diseases	
3.1. Reproductive, maternal, newborn and child health	
4.4. Health systems, information and evidence	
Outcomes:	
2.1. Increased access to interventions to prevent and manage noncommunicable diseases and their risk factors	
3.1. Increased access to interventions for improving health of women, newborns, children and adolescents	
4.4. All countries having well-functioning health information, eHealth, research, ethics and knowledge management systems to support national health priorities	
Outputs:	
2.1.3. Countries enabled to improve health care coverage for the management of cardiovascular diseases, cancer, diabetes and chronic respiratory diseases and their risk factors, including in crises and emergencies	
2.1.5. Enhanced coordination of activities, multistakeholder engagement and action across sectors in collaborative work with relevant United Nations system organizations, other intergovernmental organizations and non-State actors, to support governments to meet their commitments on the prevention and control of noncommunicable diseases	
3.1.6. Research undertaken and research capacity strengthened for sexual and reproductive and maternal health through the UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP)	
4.4.2. Countries enabled to plan, develop and implement an eHealth strategy	
2. Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.	Not applicable.
3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.	Not applicable.
4. Estimated implementation time frame (in years or months) to achieve the resolution.	48 months, pending further review.
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	US\$ 32.2 million.
2.a. Estimated resource requirements already planned for in the Programme budget 2018–2019, in US\$ millions:	US\$ 16.1 million.
2.b. Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US\$ millions:	Zero.
3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:	US\$ 16.1 million.
4. Estimated resource requirements in future programme budgets, in US\$ millions:	Not applicable (pending further review).

- 5. Resources available 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\$ 11.5 million.
 - **Remaining financing gap in the current biennium:**
US\$ 4.6 million.
 - **Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium:**
Fundraising is ongoing.

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

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	3.60	0.50	0.50	0.50	0.50	0.50	0.50	6.60
	Activities	5.00	0.75	0.75	0.75	0.75	0.75	0.75	9.50
	Total	8.60	1.25	1.25	1.25	1.25	1.25	1.25	16.10
2018–2019 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 resources to be planned	Staff	3.60	0.50	0.50	0.50	0.50	0.50	0.50	6.60
	Activities	5.00	0.75	0.75	0.75	0.75	0.75	0.75	9.50
	Total	8.60	1.25	1.25	1.25	1.25	1.25	1.25	16.10

Resolution WHA71.8 Improving access to assistive technology

A. Link to the programme budget

1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.

Programme area: 2.4. Disabilities and rehabilitation

Outcome: 2.4. Increased access to comprehensive eye care, hearing care and rehabilitation services

Output: 2.4.1. Implementation of the WHO global disability action plan 2014–2021: better health for all people with disability, in accordance with national priorities

Programme area: 3.2. Ageing and health

Outcome: 3.2. Increased proportion of people who are able to live a long and healthy life

Output: 3.2.1. Countries enabled to develop policies, strategies and capacity to foster healthy ageing across the life-course

Programme area: 4.3. Access to medicines and other health technologies, and strengthening regulatory capacity

Outcome: 4.3. Improved access to and rational use of safe, efficacious and affordable quality medicines and other health technologies

Output: 4.3.1. Access to and use of essential medicines and other health technologies improved through global guidance and the development and implementation of national policies, strategies and tools

<p>2. Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.</p> <p>Not applicable.</p>
<p>3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.</p> <p>No additional deliverables are foreseen, but existing deliverables that support establishing regional or subregional assistive technology manufacturing, procurement and supply networks (notably the production of the first draft of the World report on assistive technology) are to be scaled up and strengthened</p>
<p>4. Estimated implementation time frame (in years or months) to achieve the resolution.</p> <p>The implementation time frame is currently planned up to 2030. Work may continue beyond this date as needed.</p>
<p>B. Resource implications for the Secretariat for implementation of the resolution</p>
<p>1. Total resource requirements to implement the resolution, in US\$ millions:</p> <p>US\$ 32.5 million until 2030.</p>
<p>2.a Estimated resource requirements already planned for in the Programme budget 2018–2019, in US\$ millions:</p> <p>US\$ 2.45 million.</p> <p>2.b Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US\$ millions:</p> <p>US\$ 2.55 million.</p>
<p>3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:</p> <p>US\$ 5.0 million per biennium.</p>
<p>4. Estimated resource requirements in future programme budgets, in US\$ millions:</p> <p>US\$ 5.0 million per biennium.</p>
<p>5. Resources available to fund the implementation of the resolution in the current biennium, in US\$ millions</p> <ul style="list-style-type: none"> – Resources available to fund the resolution in the current biennium: US\$ 2.45 million. – Remaining financing gap in the current biennium: US\$ 2.55 million. – Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium: US\$ 15.0 million until 2030.

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

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	1.60	0.00	0.00	0.00	0.00	0.00	0.00	1.60
	Activity	0.20	0.15	0.05	0.15	0.05	0.20	0.05	0.85
	Total	1.80	0.15	0.05	0.15	0.05	0.20	0.05	2.45
2018–2019 additional resources	Staff	0.25	0.10	0.05	0.10	0.05	0.10	0.05	0.70
	Activity	0.60	0.20	0.10	0.20	0.25	0.25	0.25	1.85
	Total	0.85	0.30	0.15	0.30	0.30	0.35	0.30	2.55
2020–2021 resources to be planned	Staff	1.85	0.10	0.10	0.10	0.05	0.10	0.05	2.35
	Activity	0.65	0.40	0.20	0.40	0.25	0.50	0.25	2.65
	Total	2.50	0.50	0.30	0.50	0.30	0.60	0.30	5.00
Future bienniums resources to be planned	Staff	1.85	0.10	0.10	0.10	0.05	0.10	0.05	2.35
	Activity	0.65	0.40	0.20	0.40	0.25	0.50	0.25	2.65
	Total	2.50	0.50	0.30	0.50	0.30	0.60	0.30	5.00

Resolution WHA71.9 Infant and young child feeding**A. Link to the programme budget****1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.**

Programme area: 2.5. Nutrition

Outcome: 2.5. Reduced nutritional risk for improved health and well-being

Output(s): 2.5.1. Countries enabled to develop and monitor implementation of action plans to tackle malnutrition in all its forms and achieve the global nutrition targets 2025 and the nutrition components of the Sustainable Development Goals

2. Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.

Not applicable.

3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.

Not applicable.

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

Four years.

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

US\$ 5.1 million.

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

US\$ 1.7 million.

2.b. Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US\$ millions: Zero.
3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions: US\$ 3.4 million.
4. Estimated resource requirements in future programme budgets, in US\$ millions: Zero.
5. Resources available 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\$ 1.3 million. – Remaining financing gap in the current biennium: US\$ 0.4 million. – Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium: US\$ 0.1 million.

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

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	315 500	58 400	52 800	46 000	52 300	59 700	56 400	641 100
	Activities	640 000	100 000	70 000	50 000	50 000	80 000	80 000	1 070 000
	Total	955 500	158 400	122 800	96 000	102 300	139 700	136 400	1 711 100
2018–2019 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 resources to be planned	Staff	526 500	142 200	129 600	110 000	127 700	126 700	128 800	1 291 500
	Activities	640 000	250 000	250 000	250 000	250 000	250 000	250 000	2 140 000
	Total	1 166 500	392 200	379 600	360 000	377 700	376 700	378 800	3 431 500

Resolution WHA71.11 Deputy Directors-General
Resolution WHA71.12 Salaries of staff in ungraded positions and of the Director-General
A. Link to the programme budget
1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute. Programme area: 6.4. Management and administration Outcome: 6.4. Effective and efficient management and administration established across the Organization Output: 6.4.2. Effective and efficient human resources management and coordination in place

<p>2. Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.</p> <p>Not applicable.</p>
<p>3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.</p> <p>Not applicable.</p>
<p>4. Estimated implementation time frame (in years or months) to achieve the resolution.</p> <p>With respect to draft resolution 1, the related amendments to the Staff Rules will enter into force:</p> <p>(a) with effect from 1 January 2018 concerning the remuneration of staff in the professional and higher categories; and</p> <p>(b) with effect from 1 February 2018 concerning definitions, education grants, settling-in grants, repatriation grants, mobility, special leave, leave without pay, resignations, administrative reviews and the Global Board of Appeal.</p> <p>With respect to draft resolution 2, the related amendments to the Staff Regulations to reflect the current structure of the Organization will enter into force with effect from 1 January 2018.</p> <p>With respect to draft resolution 3, the related modifications to salaries of staff in ungraded posts and of the Director-General will enter into force with effect from 1 January 2018.</p> <p>There is no defined end date for implementation.</p>
<p>B. Resource implications for the Secretariat for implementation of the resolution</p>
<p>1. Total resource requirements to implement the resolution, in US\$ millions:</p> <p>Resource requirements are already included within what is planned under the Programme budget 2018–2019.</p> <p>With respect to draft resolution 1(1) and draft resolution 3 regarding modifications to staff salaries, payroll costs are always subject to some variability due to post adjustment, exchange rates, staff mix in terms of dependency and education grant entitlements among other factors, so these additional costs will be absorbed within the overall payroll budget fluctuations.</p> <p>Draft resolution 1(2) does not have any resource requirements.</p> <p>With respect to draft resolution 2, the amendments to the Staff Regulations do not in themselves have any resource requirements. However, additional positions within the current structure of the Organization are to be funded under current budget allocations.</p>
<p>2.a Estimated resource requirements already planned for in the Programme budget 2018–2019, in US\$ millions:</p> <p>Not applicable.</p> <p>2.b Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US\$ millions:</p> <p>Not applicable.</p>
<p>3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:</p> <p>Not applicable.</p>
<p>4. Estimated resource requirements in future programme budgets, in US\$ millions:</p> <p>Not applicable.</p>

<p>5. Resources available to fund the implementation of the resolution in the current biennium, in US\$ millions</p> <ul style="list-style-type: none"> – Resources available to fund the resolution in the current biennium: Not applicable. – Remaining financing gap in the current biennium: Not applicable. – Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium: Not applicable.

<p>Resolution WHA71.13 Reform of the global internship programme</p>
<p>A. Link to the programme budget</p>
<p>1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.</p> <p>Programme area: 6.4. Management and administration</p> <p>Outcome: 6.4. Effective and efficient management and administration consistently established across the Organization</p> <p>Outputs:</p> <p>6.4.2. Effective and efficient human resources management and coordination in place</p> <p>6.4.1. Sound financial practices managed through an adequate control framework</p>
<p>2. Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.</p> <p>Not applicable.</p>
<p>3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.</p> <p>Not applicable.</p>
<p>4. Estimated implementation time frame (in years or months) to achieve the resolution.</p> <p>Immediate implementation in order to reach the target of 50% of accepted interns on the programme to originate from least developed countries and middle-income countries by 2022, and then maintain the level.</p>
<p>B. Resource implications for the Secretariat for implementation of the resolution</p>
<p>1. Total resource requirements to implement the resolution, in US\$ millions:</p> <p>US\$ 11.32 million.</p>
<p>2.a. Estimated resource requirements already planned for in the Programme budget 2018–2019, in US\$ millions:</p> <p>US\$ 1.81 million.</p>
<p>2.b. Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US\$ millions:</p> <p>Zero.</p>
<p>3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:</p> <p>US\$ 4.43 million.</p>

4. Estimated resource requirements in future programme budgets, in US\$ millions: US\$ 5.08 million.
5. Resources available 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\$ 0.57 million.
– Remaining financing gap in the current biennium: US\$ 1.24 million.
– Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium: US\$ 0.2 million and possibilities for technical units to cover stipends from their activities funds (not necessarily under Category 6).

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

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	0.375	0	NA	0	0	0	0	0.375
	Activities	1.122	0.036	NA	0.012	0.143	0.043	0.081	1.437
	Total	1.497	0.036	NA	0.012	0.143	0.043	0.081	1.812
2018–2019 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 resources to be planned	Staff	0.500	0	NA	0	0	0	0	0.500
	Activities	2.855	0.124	NA	0.042	0.487	0.145	0.274	3.927
	Total	3.355	0.124	NA	0.042	0.487	0.145	0.274	4.427
Future bienniums resources to be planned	Staff	0.530	0	NA	0	0	0	0	0.530
	Activities	3.289	0.145	NA	0.049	0.574	0.171	0.323	4.551
	Total	3.819	0.145	NA	0.049	0.574	0.171	0.323	5.081

Resolution WHA71.14 Rheumatic fever and rheumatic heart disease**A. Link to the programme budget****1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.**

Communicable diseases

Outcome: 1.4. Increased and sustained access to neglected tropical disease control interventions.

Noncommunicable diseases

Outcome: 2.1. Increased access to interventions to prevent and manage noncommunicable diseases and their risk factors.

Promoting health through the life course

Outcome: 3.1. Increased access to interventions for improving health of women, newborns, children and adolescents.

Outcome: 3.5. Reduced environmental threats to health.

Health systems

Outcome: 4.3. Improved access to and rational use of safe, efficacious and affordable quality medicines and other health technologies.

Output(s):

- Output 1.4.2. Implementation and monitoring of neglected tropical disease control interventions facilitated by evidence-based technical guidelines and technical support.
- Output 2.1.3. Countries enabled to improve health care coverage for the management of cardiovascular diseases, cancer, diabetes and chronic respiratory diseases and their risk factors, including in crises and emergencies.
- Output 3.1.1. Countries enabled to improve maternal health through further expansion of access to, and improvement in the quality of, effective interventions for ending preventable maternal deaths from pre-pregnancy to postpartum and perinatal deaths (stillbirths and early neonatal deaths), with a particular focus on the 24-hour period around childbirth.
- Output 3.5.2. Norms and standards established and guidelines developed for environmental and occupational health risks and benefits associated with, for example, air and noise pollution, chemicals, waste, water and sanitation, radiation, and climate change and technical support provided at the regional and country levels for their implementation.
- Output 4.3.1. Access to and use of essential medicines and other health technologies improved through global guidance and the development and implementation of national policies, strategies and tools.

<p>2. Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.</p> <p>Not applicable.</p>
<p>3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.</p> <p>Not applicable.</p>
<p>4. Estimated implementation time frame (in years or months) to achieve the resolution.</p> <p>A process to set appropriate targets and develop a comprehensive plan of action will be developed by the Secretariat during the biennium 2018–2019. Other activities referred to in the resolution will be carried out during the bienniums 2020–2021, 2022–2023 and 2024–2025.</p>
<p>B. Resource implications for the Secretariat for implementation of the resolution</p>
<p>1. Total resource requirements to implement the resolution, in US\$ millions:</p> <p>US\$ 13.75 million.</p>
<p>2.a. Estimated resource requirements already planned for in the Programme budget 2018–2019, in US\$ millions:</p> <p>US\$ 0.05 million was planned and the requirements are US\$ 0.6 million.</p>
<p>2.b. Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US\$ millions:</p> <p>Not applicable.</p>

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

1. To assess and report on the magnitude and nature of the problem of rheumatic heart disease according to agreed targets, and monitor efforts for the prevention and control of rheumatic heart disease:
 - staff at P3 level at headquarters to support work on rheumatic heart disease at headquarters: US\$ 0.45 million.
2. To provide support to Member States in implementing national programmes on rheumatic heart disease and strengthening health systems through: improved disease surveillance; increased availability and training of the community and primary health care workforces; and ensuring reliable access to affordable prevention and treatment tools:
 - updating technical guidelines on primary and secondary prevention of rheumatic heart disease: US\$ 0.50 million
 - providing country technical support: US\$ 3.50 million.

Total: US\$ 4.45 million

4. Estimated resource requirements in future programme budgets, in US\$ millions:Biennium 2022–2023

1. To assess and report on the magnitude and nature of the problem of rheumatic heart disease according to agreed targets, and monitor efforts for the prevention and control of rheumatic heart disease:
 - staff at P3 level at headquarters to support work on rheumatic heart disease at headquarters: US\$ 0.45 million
 - activities: US\$ 0.40 million.
2. To provide support to Member States in implementing national programmes on rheumatic heart disease and strengthening health systems through: improved disease surveillance; increased availability and training of the community and primary health care workforces; and ensuring reliable access to affordable prevention and treatment tools:
 - providing country technical support: US\$ 3.50 million.

Total: US\$ 4.35 million

Biennium 2024–2025

1. To assess and report on the magnitude and nature of the problem of rheumatic heart disease according to agreed targets, and monitor efforts for the prevention and control of rheumatic heart disease:
 - staff at P3 level at headquarters to support work on rheumatic heart disease at headquarters: US\$ 0.45 million
 - activities: US\$ 0.40 million.
2. To provide support to Member States in implementing national programmes on rheumatic heart disease and strengthening health systems through: improved disease surveillance; increased availability and training of the community and primary health care workforces; and ensuring reliable access to affordable prevention and treatment tools:
 - providing country technical support: US\$ 3.50 million.

Total: US\$ 4.35 million

The total additional costs for these two bienniums (US\$ 8.70 million) are to be planned within the respective proposed programme budgets.

5. Resources available 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\$ 0.05 million.
- **Remaining financing gap in the current biennium:**
US\$ 0.55 million.

– Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium:

US\$ 0.55 million.

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

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	0.30	–	–	–	–	–	–	0.30
	Activities	0.20	0.10	–	–	–	–	–	0.30
	Total	0.50	0.10	–	–	–	–	–	0.60
2018–2019 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 resources to be planned	Staff	0.45	0.90	–	–	–	–	0.70	2.05
	Activities	0.50	1.00	–	0.40	–	–	0.50	2.40
	Total	0.95	1.90	–	0.40	–	–	1.20	4.45
Future bienniums 2022–2023 resources to be planned	Staff	0.45	0.90	–	–	–	–	0.70	2.05
	Activities	0.40	1.00	–	0.40	–	–	0.50	2.30
	Total	0.85	1.90	–	0.40	–	–	1.20	4.35
Future bienniums 2024–2025 resources to be planned	Staff	0.45	0.90	–	–	–	–	0.70	2.05
	Activities	0.40	1.00	–	0.40	–	–	0.50	2.30
	Total	0.85	1.90	–	0.40	–	–	1.20	4.35

Resolution WHA71.15 Multilingualism: respect for equality among the official languages

A. Link to the programme budget

1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.

Programme areas:

4.4. Health systems, information and evidence

6.1. Leadership and governance

6.5. Strategic communications

Outcomes:

4.4. All countries having well-functioning health information, eHealth, research, ethics and knowledge management systems to support national health priorities

6.1. Greater coherence in global health, with WHO taking the lead in enabling the different actors to play an active and effective role in contributing to the health of all people

6.5. Improved public and stakeholders' understanding of the work of WHO

Outputs:

4.4.3. Knowledge management policies, tools, networks and resources developed and used by WHO and countries to strengthen their capacity to generate, share and apply knowledge

6.1.3. WHO governance strengthened with effective oversight of governing body sessions and efficient, aligned agendas

6.5.1. Accurate and timely health information accessible through a platform for effective communication and related practices

<p>2. Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.</p> <p>Not applicable.</p>
<p>3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.</p> <p>Russian-language translations, printing and distribution of technical publications; website and journal content, digitization, citation analyses and glossary of terms.</p>
<p>4. Estimated implementation time frame (in years or months) to achieve the resolution.</p> <p>Four years, for the time-limited actions in the resolution. Ongoing corporate language services will require continuous implementation.</p>
<p>B. Resource implications for the Secretariat for implementation of the resolution</p>
<p>1. Total resource requirements to implement the resolution, in US\$ millions:</p> <p>US\$ 83.94 million for the bienniums 2018–2019 and 2020–2021.</p>
<p>2.a. Estimated resource requirements already planned for in the Programme budget 2018–2019, in US\$ millions:</p> <p>US\$ 41.60 million.</p> <p>2.b. Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US\$ millions:</p> <p>Not applicable.</p>
<p>3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:</p> <p>US\$ 42.34 million.</p>
<p>4. Estimated resource requirements in future programme budgets, in US\$ millions:</p> <p>US\$ 42.34 million.</p>
<p>5. Resources available to fund the implementation of the resolution in the current biennium, in US\$ millions</p> <ul style="list-style-type: none"> – Resources available to fund the resolution in the current biennium: US\$ 40.00 million. – Remaining financing gap in the current biennium: US\$ 1.60 million. – Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium: Zero.

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

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	19.73	2.60	3.10	–	3.25	1.43	0.14	30.25
	Activities	8.26	0.03 ^b	2.00	–	0.34 ^b	0.72	–	11.35
	Total	27.99	2.63	5.10	–	3.59	2.15	0.14	41.60
2018–2019 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 resources to be planned	Staff	20.00	2.60	3.10	–	3.25	1.50	0.14	30.59
	Activities	8.00	0.50	2.00	–	0.50	0.75	–	11.75
	Total	28.00	3.10	5.10	–	3.75	2.25	0.14	42.34
Future bienniums resources to be planned	Staff	20.00	2.60	3.10	–	3.25	1.50	0.14	30.59
	Activities	8.00	0.50	2.00	–	0.50	0.75	–	11.75
	Total	28.00	3.10	5.10	–	3.75	2.25	0.14	42.34

^a Preliminary costing, which does not necessarily include the full cost of publishing in official languages in all major offices or the full cost from a human resources perspective.

^b Activity cost for language service unit only.

Resolution WHA71.16 Poliomyelitis: containment of polioviruses	
A. Link to the programme budget	
1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.	<p>Programme area: Polio eradication.</p> <p>Outcome: No case of paralysis due to wild or type-2 vaccine-related poliovirus globally.</p> <p>Output(s): All four.</p>
2. Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.	<p>Full implementation of the resolution would support achievement of a lasting polio-free world, based on the interruption of transmission of wild and vaccine-derived polioviruses and secure containment of any poliovirus in a laboratory setting.</p>
3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.	<p>Not applicable.</p>
4. Estimated implementation time frame (in years or months) to achieve the resolution.	<p>Estimated four years to global certification, followed by additional years through the post-certification strategy (submitted to the Seventy-first World Health Assembly).</p>
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	<p>There is no incremental cost – for either activities or staffing – associated with the resolution, as the related costs had already been foreseen and budgeted in the Polio Eradication and Endgame Strategic Plan 2013–2018 and will be included as part of the post-certification strategy.</p>

<p>2.a. Estimated resource requirements already planned for in the Programme budget 2018–2019, in US\$ millions: Total: US\$ nil (staff: US\$ nil; activities: US\$ nil) as per section B.1 above.</p> <p>2.b. Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US\$ millions: Not applicable as per section B.1 above.</p>
<p>3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions: Not applicable as per section B.1 above.</p>
<p>4. Estimated resource requirements in future programme budgets, in US\$ millions: Not applicable as per section B.1 above.</p>
<p>5. Resources available to fund the implementation of the resolution in the current biennium, in US\$ millions</p> <ul style="list-style-type: none"> – Resources available to fund the resolution in the current biennium: Not applicable as per section B.1 above. – Remaining financing gap in the current biennium: Not applicable as per section B.1 above. – Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium: Not applicable as per section B.1 above.

<p>Decision WHA71(8) Addressing the global shortage of, and access to, medicines and vaccines</p>
<p>A. Link to the programme budget</p>
<p>1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this decision will contribute.</p> <p>Programme area: 4.3. Access to medicines and other health technologies, and strengthening regulatory capacity</p> <p>Outcome: 4.3. Improved access to and rational use of safe, efficacious and affordable quality medicines and other health technologies</p> <p>Output: 4.3.1. Access to and use of essential medicines and other health technologies improved through global guidance and the development and implementation of national policies, strategies and tools</p> <p>Output: 4.3.3. Improved quality and safety of medicines and other health technologies through norms, standards and guidelines, strengthening of regulatory systems, and prequalification</p>
<p>2. Short justification for considering the decision, if there is no link to the results as indicated in the Programme budget 2018–2019. Not applicable.</p>
<p>3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019. Not applicable.</p>

Decision WHA71(9) Global strategy and plan of action on public health, innovation and intellectual property: overall programme review
A. Link to the programme budget
<p>1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this decision will contribute.</p> <p>Programme area: 4.3. Access to medicines and other health technologies and strengthening regulatory capacity</p> <p>Outcome: 4.3. Improved access to and rational use of safe, efficacious and affordable quality medicines and other health technologies</p> <p>Output: 4.3.2. Implementation of the global strategy and plan of action on public health, innovation and intellectual property</p>
<p>2. Short justification for considering the decision, if there is no link to the results as indicated in the Programme budget 2018–2019.</p> <p>Not applicable.</p>
<p>3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.</p> <p>Not applicable.</p>
<p>4. Estimated implementation time frame (in years or months) to achieve the decision.</p> <p>Five years (2018 to 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\$ 31.50 million for the period 2018 to 2022.</p>
<p>2.a. Estimated resource requirements already planned for in the Programme budget 2018–2019, in US\$ millions:</p> <p>US\$ 10.80 million.</p>
<p>2.b. Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US\$ millions:</p> <p>Zero.</p>
<p>3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:</p> <p>US\$ 13.60 million.</p>
<p>4. Estimated resource requirements in future programme budgets, in US\$ millions:</p> <p>US\$ 7.10 million.</p>

<p>5. Resources available to fund the implementation of the decision in the current biennium, in US\$ millions</p> <ul style="list-style-type: none"> – Resources available to fund the decision in the current biennium: US\$ 3.00 million. – Remaining financing gap in the current biennium: US\$ 7.80 million. – Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium: Discussions are ongoing with Member States for mobilizing additional resources.

<p>Decision WHA71(10) Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan</p>
<p>A. Link to the programme budget</p>
<p>1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this decision will contribute.</p> <p>Programme areas:</p> <ul style="list-style-type: none"> 6.1. Leadership and governance 6.4. Management and administration Outbreak and crisis response <p>Outcomes:</p> <ul style="list-style-type: none"> 6.1. Greater coherence in global health, with WHO taking the lead in enabling the different actors to play an active and effective role in contributing to the health of all people 6.4. Effective and efficient management and administration consistently established across the Organization Outbreak and crisis response <p>Outputs:</p> <ul style="list-style-type: none"> 6.1.1. Effective WHO leadership and management and improved capacities of the WHO Secretariat and Member States to promote, align, coordinate and operationalize efforts to achieve the Sustainable Development Goals 6.1.2. Effective engagement with other United Nations agencies and non-State actors in building a common health agenda that responds to Member States' priorities 6.4.1. Sound financial practices managed through an adequate control framework 6.4.2. Effective and efficient human resources management and coordination in place 6.4.3. Efficient and effective computing infrastructure, corporate and health-related systems and applications 6.4.4. Provision of operational and logistics support, procurement, infrastructure maintenance and asset management, and of a secure environment for WHO staff and property Outbreak and crisis response
<p>2. Short justification for considering the decision, if there is no link to the results as indicated in the Programme budget 2018–2019.</p> <p>Not applicable.</p>
<p>3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.</p> <p>Not applicable.</p>
<p>4. Estimated implementation time frame (in years or months) to achieve the decision.</p> <p>One year: June 2018–May 2019.</p>

B. Resource implications for the Secretariat for implementation of the decision
<p>1. Total resource requirements to implement the decision, in US\$ millions: US\$ 10.11 million (staff: US\$ 3.86 million; activities: US\$ 6.25 million).</p>
<p>2.a. Estimated resource requirements already planned for in the Programme budget 2018–2019, in US\$ millions: Total: US\$ 8.25 million (staff: US\$ 3.75 million; activities: US\$ 4.50 million) to be accommodated within the existing programme budget envelope.</p>
<p>2.b. Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US\$ millions: Total: US\$ 1.86 million.</p>
<p>3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions: Not applicable.</p>
<p>4. Estimated resource requirements in future programme budgets, in US\$ millions: Not applicable.</p>
<p>5. Resources available to fund the implementation of the decision in the current biennium, in US\$ millions</p> <ul style="list-style-type: none"> – Resources available to fund the decision in the current biennium: US\$ 6 million. – Remaining financing gap in the current biennium: Funding (US\$ 4.11 million) will continue to be sought through voluntary contributions, including the strategic response plan for the occupied Palestinian territory, including east Jerusalem. – Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium: Not applicable.

Decision WHA71(11) Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits

A. Link to the programme budget

1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this decision will contribute.

Programme area: E.1 Infectious hazard management; E.2 Country health emergency preparedness and the International Health Regulations (2005)

Outcome: E.1 – All countries are equipped to mitigate risks from high-threat infectious hazards; E.2 All countries assess and address critical gaps in preparedness for health emergencies, including gaps in core capacities under the International Health Regulations (2005) and in capacities for all-hazard health emergency risk management.

Output(s): E.1.1 – Control strategies, plans and capacities developed for diseases such as cholera, viral haemorrhagic fevers, meningitis, influenza and those due to vector-borne, emerging and re-emerging pathogens; and E.1.2 – Global expert networks and innovative mechanisms developed to manage new and evolving high-threat infectious hazards (such as for clinical management, laboratories, social science, and data modelling); E.2.2 – Critical core capacities for health emergency preparedness, disaster risk management and the International Health Regulations (2005) strengthened in all countries.

<p>2. Short justification for considering the decision, if there is no link to the results as indicated in the Programme budget 2018–2019.</p> <p>During the Seventieth World Health Assembly, Member States considered the report of the 2016 PIP Framework Review Group as required under PIP Framework section 7.4.2. Further to such consideration, the Health Assembly adopted decision WHA70(10) which requests the Director-General, inter alia, to report to the Seventy-first World Health Assembly on progress in implementing the decision and to make recommendations for further action.</p>
<p>3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.</p> <p>The Secretariat aims to implement all actions within its mandate by the Seventy-second World Health Assembly. Certain elements, such as the analysis requested in paragraph 8(b) of decision WHA70(10), will be submitted as drafts in order to collect Member States' views before being finalized for submission to the Seventy-third World Health Assembly, through the Executive Board at its 146th session.</p>
<p>4. Estimated implementation time frame (in years or months) to achieve the decision.</p> <p>Up to 18 months.</p>
<p>B. Resource implications for the Secretariat for implementation of the decision</p>
<p>1. Total resource requirements to implement the decision, in US\$ millions:</p> <p>In 2017, as indicated for decision WHA70(10), total resource requirements for implementation of the recommendations of the 2016 PIP Framework Review Group were US\$ 2.91 million for implementation in 2017 and 2018–2019. For the current biennium the total resource requirements are US\$ 1.36 million.</p>
<p>2.a. Estimated resource requirements already planned for in the Programme budget 2018–2019, in US\$ millions:</p> <p>Total estimated resource requirements already allocated in Programme budget 2018–2019 are US\$ 1.36 million. Because the PIP Framework sits outside the Programme budget, implementing the decision can be accommodated without increasing the budget space.</p> <p>2.b. Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US\$ millions:</p> <p>Nil.</p>
<p>3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:</p> <p>None at this time.</p>
<p>4. Estimated resource requirements in future programme budgets, in US\$ millions:</p> <p>N/A</p>
<p>5. Resources available to fund the implementation of the decision in the current biennium, in US\$ millions</p> <ul style="list-style-type: none"> – Resources available to fund the decision in the current biennium: US\$ 0.690 million available and funded to cover 2018 costs under PIP Framework secretariat workplan 2018–2019. – Remaining financing gap in the current biennium: US\$ 0.666 million.

- **Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium:**

The main means for closing the gap is collection of the full annual Partnership Contributions from industry manufacturers. Other sources will include funding from other donors.

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

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	480 000	N/A	N/A	N/A	N/A	N/A	N/A	
	Activities	876 000	N/A	N/A	N/A	N/A	N/A	N/A	
	Total	1 356 000	N/A	N/A	N/A	N/A	N/A	N/A	
2018–2019 additional resources	Staff	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Activities	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Total	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
2020–2021 resources to be planned	Staff	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Activities	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Total	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Future bienniums resources to be planned	Staff	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Activities	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Total	N/A	N/A	N/A	N/A	N/A	N/A	N/A	

Decision WHA71(15) Implementation of International Health Regulations (2005): five-year global strategic plan to improve public health preparedness and response, 2018–2023

A. Link to the programme budget

1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this decision will contribute.

Programme area: E.2. Country health emergency preparedness and the International Health Regulations (2005)

Outcome: E.2. All countries assess and address critical gaps in preparedness for health emergencies, including in core capacities under the International Health Regulations (2005) and in capacities for all-hazard health emergency risk management

Output: E.2.4. Secretariat support provided for implementation of the International Health Regulations (2005)
The implementation of the five-year global strategic plan requires activities across the WHO Health Emergencies Programme, the cost of which is included in the overall programme budget of the Health Emergencies Programme. The cost of the implementation of the decision is understood as only the cost of the Secretariat's support for coordination of implementation, monitoring and reporting on the five-year global strategic plan.

2. Short justification for considering the decision, if there is no link to the results as indicated in the Programme budget 2018–2019.

Not applicable.

3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.

Not applicable.

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

Five years.

B. Resource implications for the Secretariat for implementation of the decision	
1. Total resource requirements to implement the decision, in US\$ millions:	US\$ 10.65 million.
2.a Estimated resource requirements already planned for in the Programme budget 2018–2019, in US\$ millions:	US\$ 2.40 million.
2.b Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US\$ millions:	None.
3. Estimated resource requirements in the Programme budget 2020–2021, in US\$ millions:	US\$ 3.94 million.
4. Estimated resource requirements in future programme budgets, in US\$ millions:	US\$ 4.31 million for 2022–2023.
5. Resources available to fund the implementation of the decision in the current biennium, in US\$ millions	
– Resources available to fund the decision in the current biennium:	None.
– Remaining financing gap in the current biennium:	US\$ 2.40 million.
– Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium:	The allocation of assessed contributions is not yet known.

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

Biennium	Costs	Headquarters	Region						Total ^a
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	0.61	0.25	0.27	0.20	0.23	0.20	0.25	2.00
	Activities	0.10	0.05	0.05	0.05	0.05	0.05	0.05	0.40
	Total	0.71	0.30	0.32	0.25	0.28	0.25	0.30	2.40
2018–2019 additional resources	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2020–2021 resources to be planned	Staff	0.63	0.52	0.56	0.42	0.48	0.41	0.51	3.52
	Activities	0.10	0.05	0.05	0.05	0.05	0.05	0.05	0.42
	Total	0.73	0.57	0.61	0.47	0.53	0.46	0.56	3.94
Future bienniums resources to be planned	Staff	0.65	0.54	0.58	0.44	0.50	0.43	0.53	3.66
	Activities	0.16	0.08	0.08	0.08	0.08	0.08	0.08	0.65
	Total ^a	0.82	0.62	0.66	0.52	0.58	0.51	0.61	4.31

^a Some totals do not add up due to rounding.