



WORLD HEALTH ORGANIZATION

SEVENTY-THIRD WORLD HEALTH ASSEMBLY

**GENEVA, 18–19 MAY (*de minimis*) and
9–14 NOVEMBER (resumed) 2020**

**RESOLUTIONS AND DECISIONS
ANNEXES**

**GENEVA
2020**

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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

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

PREFACE

The Seventy-third World Health Assembly was held virtually, using video conference technology and coordinated from WHO headquarters, Geneva, from 18 to 19 May (*de minimis*) and 9 to 14 November (resumed) 2020, in accordance with the decision of the Executive Board at its 145th session¹ and the decision of the Seventy-third World Health Assembly at its *de minimis* session.²

¹ Decision EB145(7) (2019).

² Decision WHA73(8) (2020).

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A73/20 Add.1	Evaluation of the election of the Director-General of the World Health Organization Informal consultations on the evaluation of the election of the Director-General of the World Health Organization ²
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A73/INF./2	Decade of Healthy Ageing The Global strategy and action plan on ageing and health 2016–2020: towards a world in which everyone can live a long and healthy life
A73/INF./3	Voluntary contributions by fund and by contributor, 2019
A73/INF./4	Progress report from the Co-Chairs of the Independent Panel for Pandemic Preparedness and Response

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A73/INF./6	Proposed modalities for the Seventy-third World Health Assembly (resumed)

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A73/DIV./2	Guide for delegates to the World Health Assembly
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OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES¹

President

Ms Keva BAIN (Bahamas)

and Northern Ireland, United Republic of
Tanzania and United States of America..

Vice-Presidents

Mrs Jacqueline Lydia MIKOLLO (Congo)

Mr Roberto CIAVATTA (San Marino)

Dr Viroj TANGCHAROENSATHIEN
(Thailand)

H.E. Mr LI Song (China)

Dr Akram ELTOUM (Sudan)

H.E. Dr Osama Ahmed ABDELRAHIM
(Sudan)²

Secretary

Dr Tedros Adhanom GHEBREYESUS,
Director-General

Committee on Credentials³

The Committee on Credentials was composed of delegates of the following Member States: Bulgaria, El Salvador, Japan, Liberia, Mozambique, North Macedonia, Republic of Moldova, Rwanda, Somalia, Timor-Leste, Trinidad and Tobago and Viet Nam.

General Committee

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the chairs of the main committees, together with the delegates of the following Member States: Argentina, Croatia, Cuba, Djibouti, Eritrea, Ethiopia, Fiji, France, Mongolia, Nepal, Nicaragua, Oman, Russian Federation, Sierra Leone, United Kingdom of Great Britain

Chair: Ms Keva BAIN (Bahamas)

Secretary: Dr Tedros Adhanom
GHEBREYESUS, Director-General

MAIN COMMITTEES

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

Committee A

Chair: Dr Bjørn-Inge LARSEN (Norway)

Vice-Chairs: Ms Tamara Mawhinney (Canada)
Dr Susie Perera De Silva (Sri Lanka)

Rapporteur: Dr Jane Ruth ACENG OCERO
(Uganda)

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

Committee B

Chair: H.E. Mr Mamadou Henri KONATE
(Mali)

Vice-Chairs: Dr Ahmad Jawad OSMANI
(Afghanistan)

H.E. Mrs Elizabeth WILDE (Australia)

Mr Amadou THIAM (Mali) *ad interim*

Rapporteur: Mr Tashi Penjor (Bhutan)

Secretary: Dr Clive ONDARI, Director, Health
Product Policy and Standards

REPRESENTATIVES OF THE EXECUTIVE BOARD

Dr Hiroki NAKATANI (Japan)
Dr Rajitha SENARATNE (Sri Lanka)
Dr Hussain ALRAND (United Arab Emirates)
Dr Päivi SILLANAUKEE (Finland)

¹ In addition, the list of delegates and other participants is contained in documents A73/DIV./1 Rev.1 and A73/DIV./1 Rev.1 Resumed session.

² Elected at the resumed session of the Seventy-third Health Assembly to replace Dr Akram Eltoum.

³ As per decision WHA73(18), the Committee on Credentials shall meet only in the event that a matter is referred to it by the Health Assembly or by the President of the Health Assembly.

RESOLUTIONS AND DECISIONS

RESOLUTIONS

WHA73.1 COVID-19 response¹

The Seventy-third World Health Assembly,

Having considered the address of the Director-General on the ongoing pandemic of coronavirus disease (COVID-19);²

Deeply concerned by the morbidity and mortality caused by the COVID-19 pandemic, the negative impacts on physical and mental health and social well-being, the negative impacts on economies and societies and the consequent exacerbation of inequalities within and between countries;

Expressing solidarity with all countries affected by the pandemic, as well as condolences and sympathy to all the families of the people who have died from of COVID-19;

Underlining the primary responsibility of governments for adopting and implementing responses to the COVID-19 pandemic that are specific to their national context, as well as for mobilizing the necessary resources to do so;

Recalling the constitutional mandate of WHO to act, inter alia, as the directing and coordinating authority on international health work, and recognizing the Organization's key leadership role within the broader United Nations response and the importance of strengthened multilateral cooperation in tackling the COVID-19 pandemic and its extensive negative impacts;

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

Further recalling the Director-General's declaration on 30 January 2020 that the outbreak of novel coronavirus (2019-nCoV) constituted a public health emergency of international concern, and the temporary recommendations issued by the Director-General under the International Health Regulations (2005), upon the advice of the Emergency Committee convened in response to 2019-nCoV;

Also recalling the United Nations General Assembly resolutions 74/270 (2020) on global solidarity to fight the coronavirus disease 2019 (COVID-19) and 74/274 (2020) on international cooperation to ensure global access to medicines, vaccines and medical equipment to face COVID-19;

Noting resolution EB146.R10 (2020) on strengthening preparedness for health emergencies: implementation of the International Health Regulations (2005), and reiterating the obligation for all States Parties to fully implement and comply with the International Health Regulations (2005);

¹ See Annex 3 for the financial and administrative implications for the Secretariat of this resolution.

² Document A73/3.

Noting also WHO's Strategic Preparedness and Response Plan and the United Nations' Global Humanitarian Response Plan for COVID-19;

Recognizing that the COVID-19 pandemic has a disproportionately heavy impact on poor people and those who are most vulnerable, with repercussions on health and development gains, in particular in low- and middle-income countries, thus hampering the achievement of the Sustainable Development Goals and universal health coverage, including through the strengthening of primary health care; reiterating the importance of continued and concerted efforts, and the provision of development assistance; and further recognizing with deep concern the effect of high debt levels on countries' ability to withstand the significant economic impact of COVID-19;

Recognizing further the negative health impacts of the COVID-19 pandemic, including hunger and malnutrition, increased violence against women, children, and frontline health workers, as well as disruptions in the care of older persons and persons with disabilities;

Emphasizing the need to protect populations from COVID-19, in particular people with pre-existing health conditions, older people, and other groups at risk, including health professionals, health workers and other relevant frontline workers, especially women, who represent the majority of the health workforce, as well as people with disabilities, children and adolescents, and people in vulnerable situations; and stressing the importance of age- and disability-sensitive and gender-responsive measures in this regard;

Recognizing the need for all countries to have unhindered, timely access to quality, safe, effective and affordable diagnostics, therapeutics, medicines and vaccines, and essential health technologies, and their components, as well as equipment, in order to mount the COVID-19 response;

Noting the need to ensure the safe and unhindered access of humanitarian personnel, in particular medical personnel responding to the COVID-19 pandemic, their means of transport and equipment; and to protect hospitals and other medical facilities as well as the delivery of supplies and equipment, in order to allow such personnel to efficiently and safely perform their task of assisting affected civilian populations;

Recalling United Nations General Assembly resolution 46/182 of 19 December 1991 on the strengthening of the coordination of humanitarian emergency assistance of the United Nations and all subsequent General Assembly resolutions on the subject, including resolution 74/118 of 16 December 2019;

Underscoring that respect for international law, including international humanitarian law, is essential to contain outbreaks of COVID-19 in armed conflicts and mitigate their impact;

Recognizing further the many unforeseen public health impacts, challenges and resource needs generated by the ongoing COVID-19 pandemic and the potential re-emergences thereof, as well as the multitude and complexity of necessary immediate and long-term actions, coordination and collaboration that are required at all levels of governance across organizations and sectors, including civil society and the private sector, in order to have an efficient and coordinated public health response to the pandemic, leaving no one behind;

Recognizing also the importance of planning and preparing for the recovery phase, including to mitigate the impact of the pandemic and of the unintended consequences of public health measures on society, public health, human rights and the economy;

Expressing optimism that the COVID-19 pandemic can be successfully controlled and overcome, and its impact mitigated, through leadership and sustained global cooperation, unity, and solidarity,

1. CALLS FOR, in the spirit of unity and solidarity, the intensification of cooperation and collaboration at all levels in order to contain and control the COVID-19 pandemic and mitigate its impact;
2. ACKNOWLEDGES the key leadership role of WHO and the fundamental role of the United Nations system in catalysing and coordinating the comprehensive global response to the COVID-19 pandemic, and the central efforts of Member States therein;
3. EXPRESSES its highest appreciation of, and support for, the dedication, efforts and sacrifices, above and beyond the call of duty of health professionals, health workers and other relevant frontline workers, as well as the WHO Secretariat, in responding to the COVID-19 pandemic;
4. CALLS FOR the universal, timely and equitable access to, and fair distribution of, all quality, safe, effective and affordable essential health technologies and products, including their components and precursors, that are required in the response to the COVID-19 pandemic as a global priority, and the urgent removal of unjustified obstacles thereto, consistent with the provisions of relevant international treaties, including the provisions of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) and the flexibilities within the Doha Declaration on the TRIPS Agreement and Public Health;
5. REITERATES the importance of urgently meeting the needs of low- and middle-income countries in order to fill the gaps in efforts to overcome the pandemic, through timely and adequate development and humanitarian assistance;
6. RECOGNIZES the role of extensive immunization against COVID-19 as a global public good for health in preventing, containing and stopping transmission in order to bring the pandemic to an end, once safe, quality, effective, accessible and affordable vaccines are available;
7. CALLS ON Member States,¹ in the context of the COVID-19 pandemic:
 - (1) to put in place a whole-of-government and whole-of-society response including through implementing a national, cross-sectoral COVID-19 action plan that outlines both immediate and long-term actions, with a view to sustainably strengthening their health system and social care and support systems, and preparedness, surveillance and response capacities, as well as taking into account WHO guidance, according to the national context, engaging with communities and collaborating with relevant stakeholders;
 - (2) to implement national action plans by putting in place, according to their specific contexts, comprehensive, proportionate, time-bound, age- and disability-sensitive and gender-responsive measures against COVID-19 across government sectors, ensuring respect for human rights and fundamental freedoms and paying particular attention to the needs of people in vulnerable situations, promoting social cohesion, taking the necessary measures to ensure social protection and protection from financial hardship, and preventing insecurity, violence, discrimination, stigmatization and marginalization;
 - (3) to ensure that restrictions on the movement of people and of medical equipment and medicines in the context of COVID-19 are temporary and specific and that they include exceptions for the movement of humanitarian and health workers, including community health

¹ And, where applicable, regional economic integration organizations.

workers, enabling them to fulfil their duties, and for the transfer of equipment and medicines required by humanitarian organizations for their operations;

(4) to take measures to support access to safe water, sanitation and hygiene, and infection prevention and control, ensuring that adequate attention is paid to the promotion of personal hygienic measures in all settings, including humanitarian settings, and particularly in health facilities;

(5) to ensure the continued functioning of all relevant aspects of the health system, in accordance with national context and priorities, necessary for an effective public health response to the COVID-19 pandemic and other ongoing epidemics, and the uninterrupted and safe provision of population- and individual-level services, for, among other matters, communicable diseases, including through uninterrupted vaccination programmes, and for neglected tropical diseases, noncommunicable diseases, mental health, mother and child health and sexual and reproductive health; and to promote improved nutrition for women and children, recognizing in this regard the importance of increased domestic financing and development assistance where needed in the context of achieving universal health coverage;

(6) to provide the population with reliable and comprehensive information on COVID-19 and the measures taken by authorities in response to the pandemic, and to take measures to counter misinformation and disinformation as well as malicious cyber activities;

(7) to provide access to safe testing for and treatment of COVID-19, as well as palliative care for COVID-19 patients, paying particular attention to the protection of individuals with pre-existing health conditions, older people and other people at risk, in particular health professionals, health workers and other relevant frontline workers;

(8) to provide health professionals, health workers, and other relevant frontline workers exposed to severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), with access to personal protective equipment and other necessary commodities and training, including through the provision of psychosocial support; to take measures for their protection at work, facilitating their access to the workplace and ensuring their adequate remuneration; and to consider the introduction of task-sharing and task-shifting in order to optimize the use of resources;

(9) to leverage digital technologies for the response to COVID-19, including to deal with its socioeconomic impact, paying particular attention to digital inclusion, patient empowerment, data privacy, and security, legal and ethical issues, and the protection of personal data;

(10) to provide WHO with timely, accurate and sufficiently detailed public health information related to the COVID-19 pandemic, as required by the International Health Regulations (2005);

(11) in relation to COVID-19, to share knowledge, lessons learned, experiences, best practices, data, materials, and commodities needed in the response, with WHO and other countries, as appropriate;

(12) to collaborate to promote both private sector and government-funded research and development, including open innovation, across all relevant domains, on measures necessary to contain and end the COVID-19 pandemic, in particular on vaccines, diagnostics, and therapeutics, and to share relevant information with WHO;

(13) to optimize the prudent use of antimicrobials in the treatment of COVID-19 and secondary infections in order to prevent the development of antimicrobial resistance;

(14) to strengthen actions that involve women's participation in all stages of decision-making processes, and mainstream a gender perspective in the COVID-19 response and recovery;

(15) to provide sustainable funding to the Organization to ensure that it can respond fully to public health needs in the global response to COVID-19, leaving no one behind;

8. CALLS ON international organizations and other stakeholders:

(1) to support all countries, upon their request, in implementing their multisectoral national action plans, in strengthening their health systems to respond to the COVID-19 pandemic, and in maintaining the safe provision of all other essential public health functions and services;

(2) to work collaboratively at all levels to develop, test, and scale-up production of safe, effective, quality, affordable diagnostics, therapeutics, medicines and vaccines for the COVID-19 response, including, existing mechanisms for voluntary pooling and licensing of patents in order to facilitate timely, equitable and affordable access to them, consistent with the provisions of relevant international treaties, including the provisions of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement and the flexibilities within the Doha Declaration on the TRIPS Agreement and Public Health;

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

9. REQUESTS the Director-General:

(1) to continue to work with the United Nations Secretary-General and relevant multilateral organizations, including the signatory agencies of the global action plan for healthy lives and well-being for all, on a comprehensive and coordinated response across the United Nations system to support Member States in their responses to the COVID-19 pandemic in full cooperation with governments, as appropriate, demonstrating leadership on health in the United Nations system, and to continue to act as the health cluster lead in the United Nations humanitarian response;

(2) to continue to build and strengthen the capacities of WHO at all levels to fully and effectively perform the functions entrusted to it under the International Health Regulations (2005);

(3) to assist, and continue to call upon, all States Parties to take the actions according to the provisions of the International Health Regulations (2005), including by providing all necessary support to countries for building, strengthening and maintaining their capacities to fully comply with the Regulations;

(4) to provide support to countries upon their request, in accordance with their national context, in helping to ensure the continued safe functioning of the health system in all relevant aspects necessary for an effective public health response to the COVID-19 pandemic and other ongoing epidemics, and the uninterrupted and safe provision of population- and individual-level services, for, among other matters: communicable diseases, including through undisrupted vaccination programmes, and for neglected tropical diseases, noncommunicable diseases, mental health, mother and child health and sexual and reproductive health; and to promote improved nutrition for women and children;

(5) to provide support to countries, upon request, in developing, implementing and adapting relevant national response plans to COVID-19, by developing, disseminating and updating normative products and technical guidance, learning tools, data and scientific evidence for COVID-19 responses, including to counter misinformation and disinformation, as well as malicious cyber activities, and to continue to work against substandard and falsified medicines and medical products;

(6) to continue to work closely with OIE, FAO and countries, as part of the One Health approach to identify the zoonotic source of the virus and the route of introduction to the human population, including the possible role of intermediate hosts, including through efforts such as scientific and collaborative field missions. This will enable targeted interventions and a research agenda to reduce the risk of similar events occurring, as well as to provide guidance on how to prevent infection with severe acute respiratory syndrome coronavirus 2 (SARS-COV-2) in animals and humans and prevent the establishment of new zoonotic reservoirs, as well as to reduce further risks of emergence and transmission of zoonotic diseases;

(7) to regularly inform Member States, including through the governing bodies, of the results of fundraising efforts and of the global implementation of, and allocation of financial resources through, WHO's Strategic Preparedness and Response Plan, including funding gaps and results achieved, in a transparent, accountable and swift manner, in particular in respect of the support provided to countries;

(8) rapidly, and noting paragraph 2 of United Nations General Assembly resolution 74/274 on international cooperation to ensure global access to medicines, vaccines and medical equipment to face COVID-19, and in consultation with Member States,¹ and with inputs from relevant international organizations, civil society, and the private sector, as appropriate, to identify and provide options that respect the provisions of relevant international treaties, including the provisions of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) and the flexibilities within the Doha Declaration on the TRIPS Agreement and Public Health, to be used in scaling up development, manufacturing and distribution capacities needed for transparent equitable and timely access to quality, safe, affordable and effective diagnostics, therapeutics, medicines, and vaccines for the COVID-19 response, taking into account existing mechanisms, tools, and initiatives, such as the Access to COVID-19 Tools (ACT) Accelerator, and relevant pledging appeals, such as the Coronavirus Global Response pledging campaign, to be submitted for the consideration of the governing bodies;

(9) to ensure that the Secretariat is adequately resourced to provide support to Member States in granting the regulatory approvals needed to enable timely and adequate COVID-19 countermeasures;

(10) to initiate, at the earliest appropriate moment, and in consultation with Member States,¹ a stepwise process of impartial, independent and comprehensive evaluation, including using existing mechanisms,² as appropriate, to review experience gained and lessons learned from the WHO-coordinated international health response to COVID-19 – including (i) the effectiveness of the mechanisms at WHO's disposal; (ii) the functioning of the International Health Regulations (2005) and the status of implementation of the relevant recommendations of previous Review Committees; (iii) WHO's contribution to United Nations-wide efforts; and (iv) the actions of

¹ And, where applicable, regional economic integration organizations.

² Including a Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response and the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme.

WHO and their timelines pertaining to the COVID-19 pandemic – and to make recommendations to improve capacity for global pandemic prevention, preparedness, and response, including through strengthening, as appropriate, the WHO Health Emergencies Programme;

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

(Second plenary meeting, 19 May 2020)

WHA73.2 Global strategy to accelerate the elimination of cervical cancer as a public health problem and its associated goals and targets for the period 2020–2030¹

The Seventy-third World Health Assembly,

Having adopted the written silence procedure through decision WHA73(7) (2020);²

Reaffirming resolution WHA66.10 (2013), in which the Health Assembly decided, *inter alia*, to endorse WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2020, and decision WHA72(11) (2019), in which the Health Assembly requested the Director-General to propose updates to the appendices of the global action plan, resolution WHA70.12 (2017) on cancer prevention and control in the context of an integrated approach, resolution WHA69.2 (2016) on committing to implementation of the Global Strategy for Women's, Children's and Adolescents' Health, and resolution WHA69.22 (2016), in which the Health Assembly adopted the global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021;

Recalling the political declaration of the high-level meeting on universal health coverage entitled "Universal health coverage: moving together to build a healthier world",³ including the commitment to further strengthen efforts to address noncommunicable diseases as part of universal health coverage, and the recognition that people's engagement, particularly that of women and girls, families and communities, and the inclusion of all relevant stakeholders is one of the core components of health system governance, to fully empower all people in improving and protecting their own health;

Recalling also the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases,⁴ including the commitment to promote access to affordable diagnostics, screening, treatment and care, as well as vaccines that lower the risk of cancer, including cervical cancer, as part of the comprehensive approach to its prevention and control;

Recalling further decision EB144(2) (2019), in which the Executive Board noted that urgent action is needed to scale up implementation of proven cost-effective measures towards achieving the elimination of cervical cancer as a global public health problem, including vaccination against human papillomavirus, screening and treatment of pre-cancer, early detection and prompt treatment of early invasive cancers, and palliative care, which will require political commitment and greater international cooperation and support for equitable access, including strategies for resource mobilization;

¹ See Annex 3 for the financial and administrative implications for the Secretariat of this resolution.

² See also document A73/4.

³ United Nations General Assembly resolution 74/2 (2019).

⁴ United Nations General Assembly resolution 73/2 (2018).

Emphasizing that effective interventions for the prevention (including vaccination and screening), early detection, diagnosis, treatment and care in respect of cervical cancer support the realization of the indivisible goals and targets of the 2030 Agenda for Sustainable Development, especially Goal 1 (End poverty in all its forms everywhere), Goal 3 (Ensure healthy lives and promote well-being for all at all ages), Goal 5 (Achieve gender equality and empower all women and girls) and Goal 10 (Reduce inequality within and among countries);

Deeply concerned by the significant burden of mortality and morbidity from cervical cancer and the associated suffering and stigma experienced by women, families and communities, particularly in low- and middle-income countries, and concerned by the disproportionate burden in remote and hard-to-reach areas, on marginalized communities or those in vulnerable situations, and on women and girls living with HIV, who are more likely to develop cervical cancer;

Recognizing the importance of a holistic health systems approach to cervical cancer prevention and control, integrating vaccination programmes, screening and treatment programmes, adolescent health services, HIV and sexual and reproductive health services, and communicable disease and noncommunicable disease health services, as well as the importance of inclusive and strategic national, regional and global partnerships that extend beyond the health sector;

Welcoming the prioritization of vaccination of girls against human papillomavirus as the most effective long-term intervention for reducing the risk of developing cervical cancer, and recognizing the critical importance of strengthening vaccine supply and access, including by improving affordability and reducing prices to facilitate the inclusion of the human papillomavirus vaccine in national immunization programmes;

Recognizing the urgent need to implement and scale up cervical cancer screening and treatment programmes to reduce incidence and mortality, and the urgent need to increase research and collaboration to develop cost-effective and innovative interventions for vaccination, screening, diagnosis, treatment and care in respect of cervical cancer, which could greatly increase the availability, affordability and accessibility of such interventions,

1. ADOPTS the global strategy to accelerate the elimination of cervical cancer as a public health problem and its associated goals and targets for the period 2020–2030;¹
2. URGES Member States² to implement the interventions recommended in the global strategy to accelerate the elimination of cervical cancer as a public health problem, adapted to national contexts and priorities, and embedded in strong health systems aimed at achieving universal health coverage;
3. CALLS UPON relevant international organizations and other stakeholders:
 - (1) to give priority within their respective roles and activities to supporting implementation of the global strategy to accelerate the elimination of cervical cancer as a public health problem, and to coordinate efforts in order to avoid duplication, close gaps and leverage domestic and international resources effectively;
 - (2) to work collaboratively to avoid shortages and strengthen the supply of quality, safe, effective and affordable vaccines, tests and diagnostic tools, medicines, radiotherapy and surgery in respect of human papillomavirus in order to meet the growing demand, including by reducing

¹ Global strategy to accelerate the elimination of cervical cancer as a public health problem. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/336583>, accessed 14 April 2021).

² And, where applicable, regional economic integration organizations.

prices and increasing global and local production, and to develop further cost-effective and innovative interventions for vaccination, screening, diagnosis, treatment and care;

4. REQUESTS the Director-General:

(1) to provide support to Member States, upon request, in implementing the global strategy to accelerate the elimination of cervical cancer as a public health problem, including support: to develop integrated national plans and strategies with appropriate country-specific targets; to ensure inclusion of human papillomavirus vaccine into national immunization programmes and engagement with the education sector and community stakeholders, including to close the vaccine confidence gap; to improve the availability, affordability, accessibility, utilization and quality of screening, vaccines, diagnostics, medical devices and medicines used in the prevention, treatment and care in respect of pre- and invasive cervical cancer, including radiotherapy, surgery and palliative care; and to build health workforce capacity and strengthen systems for monitoring and surveillance;

(2) to prioritize support for high-burden countries to bring evidence-based interventions to scale, mindful of the particular challenges faced by low- and middle-income countries, and cognizant of the burden on vulnerable and marginalized communities, and on women and girls who are living with HIV;

(3) to collaborate closely with relevant international organizations and stakeholders and strengthen stakeholder engagement, coordination, research, innovation and resource mobilization in order: to support implementation of the global strategy to accelerate the elimination of cervical cancer as a public health problem; to measure the impact of implementation; and to facilitate exchange of best practices between Member States;

(4) to report on progress in implementation of this resolution in 2022 and 2025 as part of the consolidated report to be submitted to the Health Assembly through the Executive Board in line with paragraph 3(e) of decision WHA72(11) (2019), and to submit a final report in 2030 with lessons learned, best practices and recommendations for further acceleration towards elimination of cervical cancer as a public health problem.

(C.L.31.2020, 3 August 2020)

WHA73.3 Global strategy for tuberculosis research and innovation¹

The Seventy-third World Health Assembly,

Having adopted the written silence procedure through decision WHA73(7) (2020);²

Concerned that tuberculosis remains the leading cause of death from a single infectious agent globally and the leading cause of death among people with HIV, responsible for an estimated 1.5 million deaths in 2018, and that the epidemic, including drug-resistant tuberculosis, poses a serious threat to health security and is a critical priority in the global response to antimicrobial resistance;

¹ See Annex 3 for the financial and administrative implications for the Secretariat of this resolution.

² See also document A73/4.

Reaffirming resolution WHA67.1 (2014), in which the Health Assembly adopted the global strategy and targets for tuberculosis prevention, care and control after 2015, known as the “End TB Strategy”,¹ including its third pillar of intensified research and innovation;

Recognizing that the 2030 milestone of ending the tuberculosis epidemic will not be met without strengthening linkages between efforts to eliminate tuberculosis and meet the relevant targets of the Sustainable Development Goals, including through universal health coverage and intensified research and innovation, linked, as appropriate, to WHO collaborating centres;

Recalling the commitments made in the political declaration of the high-level meeting of the General Assembly on the fight against tuberculosis,² as well as the Moscow Declaration to End TB,³ and recalling resolution WHA71.3 (2018), in which the Health Assembly welcomed the Moscow Declaration’s commitments and calls to action on, inter alia, pursuing science, research and innovation;

Recalling also the request, in resolution WHA71.3, that the Director-General develop a global strategy for tuberculosis research and innovation, and make further progress in enhancing cooperation and coordination in respect of tuberculosis research and development;

Reaffirming commitments made through the political declaration on HIV and AIDS⁴ and the political declaration of the high-level meeting on universal health coverage,⁵ adopted by the United Nations General Assembly, which are critical also to ending tuberculosis, and advancing related research and innovation;

Recognizing that the reduction in illness and death from tuberculosis is being challenged by antimicrobial resistance; reaffirming the importance of the political declaration of the high-level meeting of the General Assembly on antimicrobial resistance;⁶ and acknowledging that, owing to antimicrobial resistance, many other health achievements are also being gravely challenged;

Cognizant that all policies on prevention, diagnosis, treatment and care in respect of tuberculosis need to be evidence based;

Struck by the overwhelming urgency of the need to make available new tuberculosis medicines and diagnostics, and vaccines against tuberculosis;

Acknowledging that the science, research and innovation needed to develop new tools and strategies to mitigate the human, social and economic consequences of the tuberculosis epidemic should consider national contexts and circumstances;

Concerned that the pace of local innovation is often impeded by weak links between national tuberculosis programmes and public research institutes, and by a lack of adequate research infrastructure in many countries with a high burden of tuberculosis; noting the need both to create environments conducive to research, and to increase investments in, research, development and deployment of new

¹ See document EB146/10.

² United Nations General Assembly resolution 73/3 (2018).

³ Moscow Declaration to End TB. Geneva: World Health Organization (http://www.who.int/tb/Moscow_Declaration_MinisterialConference_TB/en/, accessed 4 February 2020).

⁴ United Nations General Assembly resolution 70/266 (2016).

⁵ United Nations General Assembly resolution 74/2 (2019).

⁶ United Nations General Assembly resolution 71/3 (2016).

tuberculosis medicines and diagnostics, and vaccines against tuberculosis; and recalling the importance of multisectoral and multistakeholder collaboration for research, development and innovation,

1. ADOPTS the global strategy for tuberculosis research and innovation, with its four strategic objectives:¹

- (1) to create an enabling environment for high-quality tuberculosis research and innovation;
- (2) to increase financial investments in tuberculosis research and innovation;
- (3) to promote and improve approaches to data sharing;
- (4) to promote equitable access to the benefits of research and innovation;

2. URGES all Member States:²

- (1) to adapt and implement the global strategy for tuberculosis research and innovation, including the specific actions recommended in it, according to the national context, and to provide adequate financial and other resources for implementation, including through international cooperation;
- (2) to embed the global strategy for tuberculosis research and innovation within overall actions to implement the End TB Strategy, country-specific tuberculosis research agendas and national health research strategic plans under the core principles of affordability, effectiveness, efficiency and equity;
- (3) to establish and strengthen the transfer and diffusion of knowledge in order to improve equitable access to, and promote use of, reliable, relevant, unbiased and timely tuberculosis-related health information, and to promote sharing of tuberculosis-related samples;
- (4) to establish and strengthen tuberculosis research networks in collaboration with national tuberculosis programmes, relevant international organizations, as well as non-State actors, aligned to the global strategy for tuberculosis research and innovation;
- (5) to promote an enabling environment for effective collaboration with non-State actors;
- (6) to strengthen efforts in tuberculosis research and innovation as a complement to broader cooperation to tackle antimicrobial resistance at all levels, including through national action plans on antimicrobial resistance, taking into account the work and report of the ad hoc Interagency Coordination Group on Antimicrobial Resistance;³
- (7) to adapt and use WHO's multisectoral accountability framework to monitor and track progress to end tuberculosis;

¹ Global strategy for tuberculosis research and innovation. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/336076>, accessed 14 April 2021).

² And, where applicable, regional economic integration organizations.

³ Interagency Coordination Group on Antimicrobial Resistance. No time to wait: securing the future from drug-resistant infections. Geneva: World Health Organization; 2019 (<https://www.who.int/publications/i/item/no-time-to-wait-securing-the-future-from-drug-resistant-infections>, accessed 12 August 2021).

(8) to increase investments, according to national contexts, in tuberculosis research and innovation;

3. CALLS UPON the global scientific community, international partners, non-State actors and other stakeholders, as appropriate:

(1) to provide support for the conduct and use of research and innovation aligned with country needs and focused on achieving the goals and targets of the End TB Strategy, including those contained in the political declaration of the high-level meeting of the General Assembly on the fight against tuberculosis;

(2) to establish and strengthen the transfer and diffusion of knowledge in order to improve equitable access to, and promote use of, reliable, relevant, unbiased and timely tuberculosis-related health information;

(3) to encourage the establishment of, and engage in, national, regional and global research and innovation partnerships, including public–private partnerships, to accelerate the development of tuberculosis-related affordable, safe, effective and quality medicines, vaccines, diagnostics and other health technologies, and mechanisms for their equitable delivery;

4. REQUESTS the Director-General:

(1) to provide technical and strategic support to Member States in implementing the global strategy for tuberculosis research and innovation;

(2) to promote collaboration between WHO, other entities of the United Nations system and other international agencies, as well as public and private organizations, and other relevant actors to help to implement the global strategy for tuberculosis research and innovation;

(3) to submit a report on progress in respect of the End TB Strategy, including progress on implementation of the global strategy for tuberculosis research and innovation, for consideration by the Seventy-fifth World Health Assembly in 2022, through the Executive Board at its 150th session, to inform preparations for the comprehensive review by Heads of State and Government at a United Nations high-level meeting in 2023, as requested in United Nations General Assembly resolution 73/3; and then, given the urgent action needed to end this epidemic, to report on progress to the Seventy-seventh World Health Assembly in 2024, through the Executive Board, and every two years thereafter, combined with other existing reporting requirements on tuberculosis, until 2030.

(C.L.31.2020, 3 August 2020)

WHA73.4 Integrated people-centred eye care, including preventable vision impairment and blindness¹

The Seventy-third World Health Assembly,

Having adopted the written silence procedure through decision WHA73(7) (2020);²

¹ See Annex 3 for the financial and administrative implications for the Secretariat of this resolution.

² See also document A73/4.

Recalling resolutions WHA51.11 (1998) on global elimination of blinding trachoma, WHA56.26 (2003) on the elimination of avoidable blindness, WHA59.25 (2006) and WHA62.1 (2009) on the prevention of avoidable blindness and visual impairment, WHA66.12 (2013) on neglected tropical diseases, and WHA66.4 (2013) entitled “Towards universal eye health: a global action plan 2014–2019”;

Mindful of the 2030 Agenda for Sustainable Development, in particular Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages), and recognizing the important intersections between eye health and other Sustainable Development Goals, including Goal 1 (End poverty in all its forms everywhere), Goal 4 (Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all), Goal 5 (Achieve gender equality and empower all women and girls), Goal 6 (Ensure availability and sustainable management of water and sanitation for all), Goal 8 (Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all) and Goal 10 (Reduce inequality within and among countries);

Recalling the political declaration of the high-level meeting on universal health coverage,¹ including the commitment therein to strengthen efforts to address eye health conditions as part of universal health coverage;

Recognizing that at least 2.2 billion people are living with vision impairment or blindness, of whom at least 1 billion have vision impairment that could have been prevented or is yet to be addressed;²

Acknowledging that the vast majority of people with vision impairment live in low- and middle-income countries, which often have limited resources and may lack strategies to prevent or correct vision impairment, and bearing in mind the higher prevalence of vision impairment in rural and remote areas;

Noting the significant impact of vision impairment on the development, educational achievement, quality of life, social well-being and economic independence of individuals, as well as on society, with disproportionate burdens imposed on underserved and vulnerable populations;

Aware that the majority of the causes of vision impairment can be prevented or their effects corrected through early detection and timely management, and that cost-effective interventions – covering promotion of eye health, prevention of eye conditions and vision impairment, and treatment and rehabilitation of those affected – can be made available at primary health care level to respond to the needs associated with eye conditions and vision impairment, but that there are significant variations in the use of, and access to, eye care services between and within populations;

Noting that cataract and uncorrected refractive error are the leading causes of blindness and vision impairment and that effective interventions exist for both, and emphasizing the need to improve access to these interventions for everyone, everywhere;

Concerned by barriers to availability and accessibility of eye care services, such as cataract surgery, refraction services and provision of spectacles, including shortages of trained health personnel, insufficient cross-sectoral collaboration, access challenges for people in rural and remote areas, socio-economic and cultural factors, inequities and costs of services;

¹ United Nations General Assembly resolution 74/2 (2019).

² World report on vision. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/328717>, accessed 28 January 2020).

Concerned also by the increasing prevalence of myopia, especially related to lifestyle factors in children, including intensive near vision activity and insufficient time spent outdoors;

Noting that achieving global targets for neglected tropical diseases that cause preventable blindness, especially trachoma and onchocerciasis, requires that health systems have the capacity, including adequate resources, to document, identify, screen for, treat and manage such diseases, using defined strategies, and, after verification or validation of elimination, to continue to retain people in eye care in order to manage these conditions and their complications;

Noting also that many eye conditions typically do not cause vision impairment and yet can still lead to personal and financial hardships because of associated treatment needs; and that certain of these conditions, such as pterygium, if untreated, may lead to vision impairment or blindness;

Recognizing that global eye care needs are expected to increase substantially in the coming decades due to demographic and lifestyle trends, including ageing populations globally, with the number of people living with blindness projected to triple by 2050, and with substantial increases expected in the number of cases of cataract, glaucoma, diabetic retinopathy, uncorrected refractive error and age-related macular degeneration, and with half the global population expected to be living with myopia, and stressing the importance of prevention, early detection and treatment to contain and reverse these increases;

Noting that scientific and technological advances, including new screening methods and telemedicine, have great potential to benefit eye care further, including early detection, diagnosis and treatment;

Recognizing the need to achieve equitable access to safe, effective, quality and affordable eye care services, noting that delivery models differ among and within countries, and acknowledging the need for effective regulation, oversight and collaboration between governments and other stakeholders including the private sector, as appropriate;

Appreciating the efforts made by the Member States, international partners and the Secretariat in recent years to prevent and address vision impairment, but mindful of the need for further action,

1. URGES Member States, taking into account their national circumstances and priorities, to take action to implement the recommendations in the *World report on vision*, including: to make eye care an integral part of universal health coverage; to implement integrated people-centred eye care in health systems; to promote high-quality implementation and health systems research complementing existing evidence for effective eye care interventions; to monitor trends and evaluate progress towards implementing integrated people-centred eye care; and to raise awareness and engage and empower people and communities in respect of eye care needs;
2. CALLS ON partners, including intergovernmental and nongovernmental organizations, to support Member States, as appropriate, in the national implementation of the recommendations in the *World report on vision*;
3. REQUESTS the Director-General:
 - (1) to provide technical support to Member States to implement the recommendations in the *World report on vision* as part of support to achieve universal health coverage;
 - (2) to develop additional guidance on evidence-based and cost-effective eye care interventions and approaches to facilitate the integration of eye care into universal health coverage, mindful

that approaches will need to be tailored to a range of country contexts, budgets and models of health service delivery;

(3) to support the creation of a global research agenda for eye health that includes health systems and policy research, and technological innovation for affordable eye care, as well as surveillance that promotes cross-country comparisons for monitoring global progress;

(4) to prepare, in consultation with Member States, recommendations on feasible global targets for 2030 on integrated people-centred eye care, focusing on effective coverage of refractive error and effective coverage of cataract surgery, for consideration by the Seventy-fourth World Health Assembly in 2021, through the 148th session of the Executive Board;

(5) to report on progress in the implementation of this resolution to the Seventy-seventh World Health Assembly in 2024, and to ensure that eye health is included as part of regular reporting on resolution WHA69.11 (2016) on health in the 2030 Agenda for Sustainable Development.

(C.L.31.2020, 3 August 2020)

WHA73.5 Strengthening efforts on food safety¹

The Seventy-third World Health Assembly,

Having adopted the written silence procedure through decision WHA73(7) (2020);²

Recalling resolutions WHA53.15 (2000) on food safety and WHA63.3 (2010) on advancing food safety initiatives, and acknowledging that the challenges outlined in these resolutions continue as the food safety systems of many Member States are under development and need significant improvements in their key components, such as regulatory infrastructure, enforcement, surveillance, inspection, laboratory capacity and capability, coordination mechanisms, emergency response and food safety education and training;

Recalling also the international conferences in 2019 on food safety convened by WHO, FAO, and WTO and the African Union in Addis Ababa and Geneva, which identified key actions and strategies to tackle current and future challenges to food safety globally;

Noting that food safety plays a critical role in the achievement of many of the Sustainable Development Goals and contributes to relevant areas of WHO's Thirteenth General Programme of Work, 2019–2023 and efforts to address universal health coverage;

Considering that WHO published estimates on the global burden of foodborne diseases for the first time in 2015, in which it estimated that more than 600 million cases of foodborne illnesses and 420 000 deaths could occur in a year;³ and that the burden of foodborne diseases falls disproportionately on groups in vulnerable situations and especially on children under 5 years of age, with the highest burden in developing countries;

¹ See Annex 3 for the financial and administrative implications for the Secretariat of this resolution.

² See also document A73/4.

³ WHO estimates of the global burden of foodborne diseases: foodborne disease burden epidemiology reference group 2007–2015. Geneva: World Health Organization; 2015 (<https://apps.who.int/iris/handle/10665/199350>, accessed 4 February 2020).

Recalling the World Bank study, *The safe food imperative: accelerating progress in low- and middle-income countries*,¹ which called upon national governments to increase investments in their food safety infrastructure, and which noted that foodborne diseases resulting from the consumption of unsafe foods cost low- and middle-income countries at least US\$ 110 billion in lost productivity and medical expenses annually;

Emphasizing the importance of the current WHO strategic plan for food safety including foodborne zoonoses, 2013–2022,² and noting its end date;

Noting the contribution of regional frameworks and networks to support food safety;

Recognizing that the development of standards, guidelines and recommendations by the Codex Alimentarius Commission, and their subsequent use by Member States, make a powerful contribution to food safety, and stressing the need to provide sufficient and sustainable funding for active participation in the provision of scientific advice to the Commission by experts from countries at all stages of development, especially developing countries, to underpin the elaboration by the Commission of science-based food safety standards, guidelines and recommendations;

Recognizing also that while progress has been made to strengthen national food safety systems, collective action is needed throughout all stages of the supply chain at the local, national, regional and global levels, involving different stakeholders, in order to respond to current and emerging food safety challenges including those linked to population-, age- and gender-based differences in risk analysis,³ climate change and extreme weather events, and foodborne pathogens, including the growing threat of antimicrobial resistance, food safety risks related to food fraud as well as other foodborne risks;

Underlining that a One Health approach to food safety includes managing food safety risks along the entire food and feed chain; and recognizing that the interconnection between food safety and human, animal, plant and environmental health is necessary for the protection of human life and health and food safety, and that it should be pursued in the vision and strategic objectives of WHO;

Noting the availability of existing and new guidance and tools to support Member States in the design, development, operation, evaluation and monitoring of their national food control systems, such as the Principles and Guidelines for National Food Control Systems (CXG 82-2013) and the Principles and Guidelines for Monitoring the Performance of National Food Control Systems (CXG 91-2017) as well as the FAO–WHO Food control system assessment tool (2019)⁴ adopted by the Codex Alimentarius Commission;

Acknowledging the global relevance of the International Food Safety Authorities Network (INFOSAN) and its importance, especially during foodborne disease emergencies;

¹ Jaffee S, Henson S, Unnevehr L, Grace D, Cassou E. *The safe food imperative: accelerating progress in low- and middle-income countries*. Washington DC: International Bank for Reconstruction and Development and The World Bank; 2019 (<https://openknowledge.worldbank.org/handle/10986/30568>, accessed 4 February 2020).

² *Advancing food safety initiatives: strategic plan for food safety including foodborne zoonoses 2013-2022*. Geneva: World Health Organization; 2013 (<https://apps.who.int/iris/handle/10665/101542>, accessed 5 February 2020).

³ See Joint FAO/WHO Food Standards Programme. Codex Alimentarius Commission: procedural manual, twenty-seventh edition. Rome: Food and Agriculture Organization of the United Nations; 2019:128 (<http://www.fao.org/3/ca2329en/CA2329EN.pdf>, accessed 5 February 2020).

⁴ See FAO and WHO. Food control system assessment tool: introduction and glossary. Rome: Food and Agriculture Organization of the United Nations; 2019 <https://apps.who.int/iris/handle/10665/329866>, accessed 4 January 2021.

Recognizing that innovation and developments in science and technology are advancing and, in particular, that data relevant to food safety are increasingly available, and that technology to derive insights from data is increasingly affordable; that these contribute to and support the design, management, reinforcement, implementation and maintenance of effective national food safety systems; and that such approaches hold promise for improved food safety outcomes throughout all stages of the global supply chain, thereby also increasing consumer confidence;

Recalling that food business operators, at every stage of the food chain, have the role of, and responsibility for, ensuring the safety of their food products,

1. URGES Member States:¹

- (1) to remain committed at the highest political level: to recognizing food safety as an essential element of public health; to developing food safety policies that take into consideration, as applicable, at all stages of the supply chain, the best available scientific evidence and advice as well as innovation; and to providing adequate resources at appropriate levels for improving systems to ensure food safety;
- (2) to integrate food safety into national and regional policies on health, agriculture, trade, environment and development, as a means to implement the 2030 Agenda for Sustainable Development, and to take coherent actions across all relevant sectors in order to promote food safety, while recognizing consumer interests;
- (3) to strengthen cross-sector collaboration, using a health-in-all-policies approach, and to apply a One Health approach to promote the sustainability and availability of, and access to, safe, sufficient and nutritious food for all populations, while recognizing the importance of affordability;
- (4) to participate actively, and support inclusive participation, in the standard-setting work of the Codex Alimentarius Commission, including as a Member State, donor or beneficiary of the Codex Trust Fund, as well as by supporting the joint expert bodies of WHO and FAO, including through the provision of experts and data; and to take into account Codex standards, guidelines and recommendations when developing national legislation;
- (5) to enhance participation in the International Food Safety Authorities Network (INFOSAN), including supporting the timely transmission of data, information and knowledge about food-safety emergencies; and to further develop and implement the core capacities required for participation in the Network;
- (6) to promote coherent actions to tackle foodborne antimicrobial resistance, including by actively supporting the work of relevant national bodies together with intergovernmental groups, such as the Codex ad hoc Intergovernmental Task Force on Antimicrobial Resistance;
- (7) to promote increased use of Codex standards, guidelines and recommendations by governments, food business and other relevant operators, at all levels;
- (8) to provide appropriate investment in national food safety systems and innovations in order to prevent food safety threats, including those associated with food fraud, and enable a rapid and appropriate response to food safety emergencies;

¹ And, where applicable, regional economic integration organizations.

(9) to improve the availability, sharing and use of scientific data and evidence to support food safety decisions, including through the systematic monitoring of foodborne hazards and surveillance of foodborne disease outbreaks, as well as through timely reporting of this information through the International Food Safety Authorities Network (INFOSAN);

(10) to promote the use of food safety management tools among food business operators at all levels, including small-scale producers, and to encourage private sector investment in safe and sustainable production and supply chains;

(11) to recognize that consumers also have a role in managing food safety risks under their control and that, where relevant, they should be provided with information on how to achieve this, through the promotion of a culture of food safety by means of education and training in communities and schools in order to foster dialogue and inspire actions that enhance public awareness of food safety and that are aimed at increasing public confidence;

(12) to recognize World Food Safety Day as an important milestone and a platform for raising awareness at all levels of the importance of food safety, and for promoting and facilitating actions to prevent foodborne diseases at local, national, regional and global levels;

(13) to participate in national, regional and global activities aimed at applying innovative food safety strategies, including enhancing traceability and early detection of contamination, to improve the supply chain and promote cost-effective and efficient food safety systems and simple, easy-to-use laboratory analysis;

2. REQUESTS the Director-General:

(1) to update, in coordination with FAO, and in consultation with Member States and OIE, the WHO global strategy for food safety¹ in order to address current and emerging challenges, incorporating new technologies and including innovative strategies for strengthening food safety systems, and to submit a report for consideration by the Seventy-fifth World Health Assembly in 2022;

(2) to explore with the Director-General of FAO a method for coordinating the two agencies' strategic efforts on food safety, and to provide a report on this proposed method to the Seventy-fifth World Health Assembly, and through the Director-General of FAO to FAO's governing bodies, as appropriate;

(3) to strengthen WHO's capacities and resources for fulfilling its leadership role, together with FAO, as founding organizations of the Codex Alimentarius Commission, in promoting the use of Codex standards, guidelines and recommendations, and in providing support to Member States, upon request, in developing and implementing food safety policies;

(4) to ensure sustainable, predictable and sufficient resources from WHO for the provision of timely scientific advice on food safety to the Codex Alimentarius Commission in order to facilitate the timely development by Codex of its standards, guidelines and recommendations, including by increasing the level of financial and in-kind contributions to support the Codex Alimentarius Commission and its work;

¹ WHO global strategy for food safety: safer food for better health. Geneva: World Health Organization; 2002 (<https://apps.who.int/iris/handle/10665/42559>, accessed 7 February 2020).

- (5) to pursue, in cooperation with FAO, the further development of the International Food Safety Authorities Network (INFOSAN) to facilitate increased use of the Network by its members, including their rapid sharing of information on food hazards and risks;
- (6) to pursue, in cooperation with FAO, effective and responsive training and capacity-building of members of the International Food Safety Authorities Network (INFOSAN);
- (7) to facilitate understanding by Member States of developments in epidemiological and laboratory sciences and technologies in food and agriculture that provide new tools for risk assessment and management of food safety systems, and surveillance and outbreak response in respect of foodborne illness, and to support Member States' ability to assess the challenges and opportunities linked to the use of new and appropriate technologies in food safety, including the importance of fully realizing the benefits of such technologies by sharing the data generated;
- (8) to place greater emphasis on food safety by encouraging the development of food safety infrastructure, including by collaborating with financial institutions, donor organizations, other multilateral organizations and regional economic communities in order to continue advancing the public health, social and economic benefits of improved food safety;
- (9) to facilitate the exchange of knowledge and expertise with other relevant organizations, collaborating with them: to support the capacity-building of food safety systems in low- and middle-income countries; to conduct surveillance, investigation, control and reporting of foodborne illness and outbreaks; and to enable every actor of the food system to fulfil their responsibilities in the production and supply of safe food;
- (10) to monitor regularly, and to report to Member States on, the global burden of foodborne and zoonotic diseases at national, regional and international levels, and in particular to prepare, by 2025, a new report on the global burden of foodborne diseases with up-to-date estimates of mortality, as well as incidence, and burden in terms of disability-adjusted life years;
- (11) to report to the Seventy-fifth World Health Assembly on progress made in implementing this resolution.

(C.L.31.2020, 3 August 2020)

WHA73.6 Evaluation of the election of the Director-General of the World Health Organization: amendments to contract¹

The Seventy-third World Health Assembly,

I

Having considered the report on the evaluation of the election of the Director-General of the World Health Organization;²

Wishing to extend the transition period between the election of future Directors-General and their taking office;

¹ See Annex 3 for the financial and administrative implications for the Secretariat of this resolution.

² Document A73/20.

Pursuant to Article 31 of the Constitution and Rules 108, 109 and 122 of the Rules of Procedure of the World Health Assembly,

(1) SUSPENDS Rule 108 of the Rules of Procedure of the World Health Assembly in relation to the length of the term of office of the Director-General to allow for an extension of one and a half months;

(2) APPROVES the amendments to the contract establishing the terms and conditions of appointment, salary and other emoluments for the post of Director-General.¹

II

Pursuant to Rule 112 of the Rules of Procedure of the World Health Assembly,

AUTHORIZES the President of the Seventy-third World Health Assembly to sign the amendment to this contract in the name of the Organization.

(Third plenary meeting, resumed session, 13 November 2020 –
Committee B, first report)

WHA73.7 Salaries of staff in ungraded posts and of the Director-General²

The Seventy-third World Health Assembly,

Noting the recommendations of the Executive Board with regard to remuneration of staff in ungraded posts and of the Director-General,³

1. ESTABLISHES the salary of each Assistant Director-General and Regional Director at US\$ 182 411 gross per annum with a corresponding net salary of US\$ 135 891;
2. ESTABLISHES the salary of the Deputy Director-General at US\$ 200 998 gross per annum with a corresponding net salary of US\$ 148 159;
3. ESTABLISHES the salary of the Director-General at US\$ 251 859 gross per annum with a corresponding net salary of US\$ 189 801;
4. DECIDES that those adjustments in remuneration shall take effect from 1 January 2020.

(Third plenary meeting, resumed session, 13 November 2020 –
Committee B, first report)

¹ See Annex 1.

² See Annex 3 for the financial and administrative implications for the Secretariat of this resolution.

³ See document A73/22.

WHA73.8 Strengthening preparedness for health emergencies: implementation of the International Health Regulations (2005)¹

The Seventy-third World Health Assembly,

Having considered the report by the Director-General on WHO's work in health emergencies,² and the report of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme;³

Reaffirming resolution WHA58.3 (2005) on revision of the International Health Regulations, in which the Health Assembly urged Member States, inter alia, to build, strengthen and maintain the capacities required under the International Health Regulations (2005), and to mobilize the resources necessary for that purpose; to collaborate actively with each other and WHO; to provide support to developing countries and countries with economies in transition upon request; and to take all appropriate measures for furthering the purpose and eventual implementation of the International Health Regulations (2005);

Recalling the commitments made through the Sustainable Development Goals, including to strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks;

Recalling further WHO's Thirteenth General Programme of Work, 2019–2023, and its strategic priority of one billion more people better protected from health emergencies by 2023;

Taking note of the 2019 annual report of the independent Global Preparedness Monitoring Board;⁴

Concerned with the continued risk of the occurrence of health emergencies, their multiple and long-term public health consequences and their negative impact on the well-being of people around the world, particularly among vulnerable groups and people in vulnerable situations, including populations in conflict-affected areas and settings prone to natural disasters;

Recognizing the potentially catastrophic human and economic impact of a pandemic on any country and on the world, and that vulnerable and low-resourced communities would be hit harder given their limited access to safe water, sanitation and hygiene services and the lack of resilient health systems that have a solid public health infrastructure and provide access for all to essential health services and quality, safe, effective and affordable essential medicines and vaccines;

Recalling United Nations General Assembly resolution 74/118 (2019) on strengthening the coordination of emergency humanitarian assistance of the United Nations;

Noting the International Conference of the Red Cross and the Red Crescent resolution 33IC/19/R3 (2019) entitled "Time to act: Tackling epidemics and pandemics together", which recalls the obligations to respect and protect the wounded and sick, health care personnel and facilities, as well as medical transports, and to take all reasonable measures to ensure safe and prompt access to health care for the wounded and sick, in times of armed conflict or other emergencies, in accordance with the applicable

¹ See Annex 3 for the financial and administrative implications for the Secretariat of this resolution.

² Document A73/11.

³ Document A73/10.

⁴ A world at risk – annual report on global preparedness for health emergencies. Geneva: World Health Organization; 2019 (https://apps.who.int/gpmb/annual_report.html, accessed 8 February 2020).

legal frameworks; and resolution 33IC/19/R2 (2019) entitled “Addressing mental health and psychosocial needs of people affected by armed conflicts, natural disasters and other emergencies”, which reaffirms, inter alia, the fundamental premise and commitment to “do no harm”;

Alarmed by increasing attacks on medical personnel and facilities and by the lack of access to medical services that is a consequence of these attacks;

Noting WHO’s leadership role in the development and implementation of the Surveillance System for attacks on health care for systematic collection and dissemination of data on attacks on health facilities, health workers, health transport and patients in complex humanitarian emergencies, in response to resolution WHA65.20 (2012) on WHO’s response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies;

Recalling the Addis Ababa Action Agenda of the Third International Conference on Financing for Development, which encourages countries to consider setting nationally appropriate spending targets for quality investments in essential public services for all, including health, education, energy, water and sanitation, consistent with national sustainable development strategies; and which makes a commitment to strong international support for these efforts;

Recognizing that investments in preparedness further social and economic benefits and advance shared goals, such as strengthening health systems in order to achieve universal health coverage and the Sustainable Development Goals;

Acknowledging that addressing social determinants of health and reducing health inequities, including through the provision of education and health literacy as well as access to health services and sanitation, are fundamental in strengthening public health preparedness;

Stressing that investments to strengthen country and regional preparedness capabilities and capacities for health emergencies will reduce losses resulting from future emergencies and contribute to shared economic and social prosperity by stimulating innovation and promoting economic development, including by reducing potential investment risks;

Recalling decision WHA71(15) (2018) on implementation of the International Health Regulations (2005), in which the Health Assembly decided, inter alia, to welcome with appreciation the five-year global strategic plan to improve public health preparedness and response, 2018–2023, and acknowledging progress made in its implementation;

Recalling further United Nations General Assembly resolutions 72/139 (2017), which underlines the role of resilient health systems in responding to outbreaks, and 70/183 (2015), which recognizes the primary role of Member States in preventing, preparing for and responding to outbreaks of infectious diseases, including those that become humanitarian crises, highlighting the critical role of WHO as the directing and coordinating authority on international health work, and the roles of the United Nations humanitarian system, regional organizations, nongovernmental organizations, the private sector and other humanitarian actors in providing financial, technical and in-kind support in order to bring epidemics under control;

Recalling also resolution WHA65.20 (2012) on WHO’s response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies, which recognizes that WHO is in a unique position to support health ministries and partners, as the global health cluster lead agency, in coordinating preparations for, the response to and the recovery from humanitarian emergencies, and calls on Member States and donors to strengthen national risk management, health emergency preparedness and contingency planning processes and disaster management units;

Further recalling the political declaration of the United Nations high-level meeting on universal health coverage,¹ which emphasized the need to enhance emergency health preparedness and response systems, as well as the United Nations General Assembly resolution 74/20 (2019) on global health and foreign policy: an inclusive approach to strengthening health systems, which encourages Member States to develop primary health care preparedness for health emergencies, to support and complement national and regional strategies, policies and programmes, and surveillance initiatives;

Recognizing the importance of both global and regional support as well as domestic resources and recurrent spending for preparedness as an integral part of national and global preparedness, universal health coverage and the Sustainable Development Goals;

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

Taking note of the 2019 Inter-Parliamentary Union resolution on achieving universal health coverage by 2030 and its emphasis on the need for strong capacities to prevent, detect and respond to public health risks;

Recalling the need for substantially increasing the number of cities and human settlements adopting and implementing integrated policies and plans towards inclusion, resource efficiency, mitigation and adaptation to climate change and air pollution, resilience to disasters, and developing and implementing, in line with the Sendai Framework for Disaster Risk Reduction 2015–2030, holistic disaster risk management at all levels;

Recognizing that urban settings are especially vulnerable to infectious disease outbreaks and epidemics, given the concentration of human activity, especially as hubs of trade and travel;

Acknowledging that long-term, sustained community engagement is crucial for early detection and response to outbreaks, and for controlling amplification and spread, ensuring trust and social cohesion, and fostering effective responses;

Recognizing the need to involve women, young people, people with disabilities, and older people in planning and decision-making, and the need to ensure that during health emergencies, health systems ensure the delivery of and universal access to health care services, including those for strong routine immunization, mental health and psychosocial support, trauma recovery, sexual and reproductive health, and maternal, newborn and child health;

Recognizing further the vital role in all phases of health emergencies (prevention, detection and response) of a motivated, skilled, and well-trained and well-resourced health workforce – including, where appropriate, community health workers – for actions at all levels;

Acknowledging that strengthening, as appropriate, national, subnational, regional and global emergency medical teams is a high-impact investment in preparedness for disasters, outbreaks, epidemics and other health emergencies;

Recognizing WHO's contribution to strengthening global preparedness and response to health emergencies and welcoming the work of the WHO Health Emergencies Programme;

¹ United Nations General Assembly resolution 74/2 (2019).

Noting WHO's portal for the Strategic Partnership for International Health Regulations (2005) and Health Security as a tool for monitoring progress in health security capacities, identification of needs, gaps and priorities, and mapping and sharing of information on investment and resources;

Reaffirming the principles of humanity, neutrality, impartiality and independence in the provision of humanitarian assistance, and reaffirming the need for all actors engaged in the provision of humanitarian assistance in situations of complex humanitarian emergencies and natural disasters to promote and fully respect these principles,

1. URGES Member States:¹

(1) to fully comply with the International Health Regulations (2005), to take actions to implement the unmet obligations thereof, and to continue to build core capacities to detect, assess, report on and respond to public health events as set out in the International Health Regulations (2005), while mindful of the purpose and scope of the Regulations to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade;

(2) to prioritize at the highest political level the improvement of, and coordination for, health emergency preparedness in order to enable an inclusive multisectoral, all-hazards, health-in-all-policies and whole-of-society approach to preparedness, including, as appropriate, collaboration with civil society, academic institutions and the private sector;

(3) to improve national coordination and collaboration regionally, internationally and with all stakeholders, in particular the Secretariat, to optimize mechanisms and the use of resources to avoid gaps in or duplication of efforts; and, as appropriate, coordination and collaboration across borders, including according to the provisions of the International Health Regulations (2005);

(4) to prioritize community involvement and capacity-building in all preparedness efforts, building trust and engaging multiple stakeholders from different sectors;

(5) to take action to engage and involve women in all stages of preparedness processes, including in decision-making, and to mainstream gender perspective in preparedness planning and emergency response;

(6) to continue to strengthen the capacities of health systems in health emergency preparedness and in providing during health emergencies continued access to affordable essential health services and primary health care, including mental health and psychosocial services, and services for people with disabilities;

(7) to dedicate domestic investments and recurrent spending and public funding to health emergency preparedness in priority setting, and in budgeting processes for health system strengthening, and across relevant sectors; and, where necessary, to work with partners to secure sustained funding;

(8) to improve governance and decision-making processes and enhance institutional and operational capacity and infrastructure for public health, including scientific and laboratory capacity and operational and research competence of national public health institutions, as appropriate to national circumstances, as well as a cross-sectoral infrastructure for delivering

¹ And, where applicable, regional economic integration organizations.

essential public health functions, including the capacity to tackle existing and emerging health threats and risks;

2. CALLS UPON Member States, regional economic integration organizations, international, regional and national partners, donors and other partners:

(1) to provide political, financial and technical support through multisectoral efforts, to strengthen country capacities for health emergencies as an integral part of the Sustainable Development Goals, in particular in the most under-resourced, vulnerable and at-risk countries, through development assistance for health and timely provision of humanitarian funding;

(2) to continue supporting countries in the development of health emergency preparedness and implementation of core capacities under the International Health Regulations (2005), including, as appropriate, through national plans for implementation of the Regulations and/or, where relevant, national action plans for health security;

(3) to expand support for development and implementation of multisectoral national action plans and policies for preparedness, using an all-hazards and, as appropriate, One Health approaches, further enhancing synergies with health system strengthening, disease prevention and control, research and innovation, disaster risk management and relevant national plans in key sectors to enhance preparedness;

(4) to integrate evaluation of preparedness risks and resource needs into systematic institutional, policy and economic risk assessments, as well as into existing financing mechanisms across all relevant organizations;

(5) to support the provision of appropriate remuneration, resources and training to health professionals, especially those cadres typically under-represented in the health workforce, such as epidemiologists and mental health professionals, and strengthen, in particular, the role of the local health workforce, and the development of effective and high-performing national, subnational and regional emergency medical teams, as appropriate, in line with WHO classification and minimum standards;

(6) to facilitate investment in strong national research agendas and adequate infrastructures for research and development in support of new measures to counteract the impact of health emergencies, including non-pharmaceutical interventions;

(7) to assess the vulnerabilities of cities and other human settlements to health emergencies, paying particular attention to communicable disease outbreaks, and to enhance preparedness by integrating policies, plans and exercises across health, urban planning, water and sanitation, environmental protection and other relevant sectors, to ensure local leadership and community involvement;

(8) to pursue support for the sustainable financing of WHO's preparedness and response activities and the Contingency Fund for Emergencies;

(9) to encourage, promote and share information about strategic partnerships and technical collaboration for preparedness, including those between relevant international, regional and national institutions, in particular national public health institutes, including through the WHO Global Strategic Preparedness Network;

3. CALLS on Member States¹ and the Director-General to work with the Secretary-General of the United Nations and the United Nations Office for the Coordination of Humanitarian Affairs and other relevant organizations of the United Nations system:

- (1) to strengthen United Nations system-wide coordination in different country, health and humanitarian emergency contexts;
- (2) to systematically review and revise United Nations preparedness and response strategies for outbreaks;
- (3) to enhance United Nations system leadership for preparedness and response coordination, including through United Nations system-wide simulation exercises;
- (4) to increase collaboration between relevant actors to accelerate preparedness for pandemics and disease outbreaks, in particular in fragile situations and conflict-affected areas;

4. REQUESTS the Director-General:

- (1) to support States Parties, upon their request, to review their implementation of the International Health Regulations (2005) by using, as appropriate, available tools included in the International Health Regulations (2005) monitoring and evaluation framework;
- (2) to allocate the necessary financial and human resources at all levels of the Organization for activities to support countries in improving health emergency preparedness;
- (3) to participate in United Nations operational reviews after major health emergencies and report in a timely manner to the Health Assembly, through the Executive Board, on lessons learned and recommendations for further action;
- (4) to conduct a study in consultation with Member States on the need for and potential benefits of and, as appropriate, make proposals to the Seventy-fourth World Health Assembly through the Executive Board, on possible complementary mechanisms to be used by the Director-General to alert the global community about the severity and/or magnitude of a public health emergency in order to mobilize necessary support and to facilitate international coordination;
- (5) to report to the Health Assembly, through the Executive Board, on the methodology and the implementation and findings of the Surveillance System for attacks on health care in complex humanitarian emergencies, in line with resolution WHA65.20 (2012), as part of the regular reporting on the WHO Health Emergencies Programme;
- (6) to report on the implementation of this resolution in connection with the annual reporting on WHO's work in emergencies, and annual reporting on the implementation of the International Health Regulations (2005), until the Seventy-seventh World Health Assembly.

(Third plenary meeting, resumed session, 13 November 2020 –
Committee A, first report)

¹ And, where applicable, regional economic integration organizations.

WHA73.9 Global road map on defeating meningitis by 2030¹

The Seventy-third World Health Assembly,

Recalling resolutions WHA70.7 (2017) on improving the prevention, diagnosis and clinical management of sepsis; WHA70.13 (2017) on prevention of deafness and hearing loss; WHA70.14 (2017) on strengthening immunization to achieve the goals of the global vaccine action plan; and WHA71.1 (2018) on WHO's Thirteenth General Programme of Work, 2019–2023;

Noting the reports by the Director-General on WHO's Thirteenth General Programme of Work² and the global vaccine action plan;³ and the draft document, *Defeating meningitis by 2030: a global road map*;⁴

Recalling that meningitis remains a threat in all countries of the world that presents a major challenge for health systems, especially those that can be significantly disrupted in the case of epidemics, and recognizing in particular the burden of bacterial meningitis;⁵

Further recalling that the burden of meningitis is greatest in developing countries, in particular in the sub-Saharan meningitis belt;

Recognizing that beyond the burden of the disease, and the severe sequelae and high mortality rate for which it can be responsible, meningitis has a heavy social and economic cost, especially because of the loss of productivity on the part of affected individuals and their families, and the very high costs of providing care and support to those with long-term sequelae, both within and outside the health sector;

Acknowledging that the prevention and control of meningitis require a coordinated and multidisciplinary approach, with equity and sustainability as core principles;

Recognizing the need to strengthen routine immunization, one of the most successful and cost-effective interventions in public health and a fundamental element of primary health care;

Acknowledging that efforts to prevent meningitis will also help to reduce the burden of other illnesses, such as sepsis and pneumonia, due to meningitis-causing pathogens;

Further acknowledging that meningitis control is a matter of emergency response, in the case of outbreaks, and that meningitis is also associated with impaired economic and social development where the disease is endemic;

Affirming that achieving the Sustainable Development Goals – particularly Goal 3 (Ensure healthy lives and promote well-being for all at all ages) – and universal health coverage could reduce the prevalence and spread of meningitis;

Reiterating the obligation for all States Parties to fully implement and comply with the International Health Regulations (2005);

¹ See Annex 3 for the financial and administrative implications for the Secretariat of this resolution.

² Document A71/4.

³ Document A73/6.

⁴ Defeating meningitis by 2030: a global road map. Geneva: World Health Organization; 2020.

⁵ Defeating meningitis by 2030: baseline situation analysis. Geneva: World Health Organization; 2019.

Acknowledging that, as meningitis has epidemic potential, strong national surveillance and reporting systems are needed for its effective management and control,

1. APPROVES the global road map on defeating meningitis by 2030;¹
2. URGES Member States:²
 - (1) as appropriate to national context, to identify meningitis as a political priority through its inclusion in national policies and plans, either as a stand-alone plan or embedded within broader health initiatives;
 - (2) to establish national targets and to develop and implement, in the context of national priorities, through an integrated meningitis control plan, multidisciplinary, selected, cost-effective prevention and control measures and provision of services, including equitable access to safe, effective, good-quality and affordable vaccines, and treatments, prophylactic measures, targeted control interventions, diagnostics, appropriate health care, including rehabilitation care, and sustainable financing models adapted to the local transmission pattern for long-term control and elimination of epidemics;
 - (3) to ensure that national policies and plans regarding the prevention and management of meningitis cover all areas at high risk of meningitis transmission;
 - (4) in partnership with other groups involved in care for persons with disabilities, to develop and strengthen services aiming to reduce the burden of sequelae for individuals who had previously contracted meningitis and who now live with disabilities;
 - (5) to establish, in line with national contexts and priorities, integrated national multidisciplinary meningitis prevention and surveillance mechanisms, to coordinate the implementation of the meningitis control plan, including representation of the different ministries, agencies, partners, civil society organizations and communities involved in meningitis control efforts and rehabilitation services;
 - (6) in order to reduce the public health, social and economic impact of meningitis, to strengthen national 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 epidemics of meningitis;
 - (7) to strengthen surveillance and early reporting of meningitis by national surveillance systems in line with the International Health Regulations (2005) and national priorities, and build capacity for data collection and analysis, including for sequelae;
 - (8) to strengthen community engagement, communication and social mobilization in meningitis prevention, early detection, health-seeking behaviour, rehabilitation and other related activities;
 - (9) to support, including through international cooperation, research and innovation to better prevent and control meningitis by means of: improved vaccines and vaccination strategies; better

¹ Global road map on defeating meningitis by 2030. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/342010>, accessed 1 October 2021).

² And, where applicable, regional economic integration organizations.

early diagnostics, treatment and medicines, and identification and management of sequelae; and monitoring of antimicrobial resistance;

(10) to consider the implementation of the points above in the light of the overall national context and the objective of health system strengthening and universal health coverage;

3. REQUESTS the Director-General:

(1) to reinforce advocacy, strategic leadership and coordination with partners at all levels including, as appropriate, by means of the Technical Taskforce on defeating meningitis by 2030;

(2) to increase capacity to provide support to countries to scale up their ability to implement and monitor multidisciplinary, integrated interventions: for long-term meningitis prevention and control, including elimination of epidemics and provision of access to appropriate support and care services for affected people and families; for preparedness and response to meningitis epidemics, in accordance with the global initiative “Defeating meningitis by 2030” and aligned with national plans to encourage reporting and monitor progress and disease burden in order to inform country and global strategies; and for control or elimination of epidemics;

(3) to provide support to countries, upon request, in the assessment of meningitis risk factors and capacity for multidisciplinary engagement, within existing technical resources and in line with national contexts and priorities;

(4) to continue leading the management of the meningitis vaccine stockpile, developing strategies to ensure sufficient vaccine stockpile at the optimal level (global, regional, national or subnational) in consultation with Member States and in collaboration with partners and vaccine manufacturers, while promoting expansion and diversification of vaccine producers; and to promote equitable access, including by providing support to gradually transition from polysaccharide to safe, good-quality, effective, affordable multivalent meningococcal conjugate vaccines to respond to outbreaks, and where appropriate, supporting vaccination campaigns, in cooperation with relevant organizations and partners, including but not limited to the International Federation of Red Cross and Red Crescent Societies, Médecins Sans Frontières International, UNICEF and Gavi, the Vaccine Alliance;

(5) to monitor and support, upon request, long-term meningitis prevention and control programmes at country and regional levels;

(6) to develop and promote an outcome-oriented research and innovation agenda for meningitis, in particular in developing countries, targeted at: closing important knowledge gaps; improving implementation of existing interventions, including best prevention practices and rehabilitation; and developing improved vaccines and vaccination strategies for better and more durable prevention and outbreak control, covering all aspects of meningitis control;

(7) to raise the profile of meningitis at the highest levels on the global public health agenda, and to strengthen the coordination and engagement of multiple sectors;

(8) to submit a report to the Executive Board at its 150th session on progress in implementing this resolution, and a report to the Seventy-sixth World Health Assembly, through the Executive Board at its 152nd session, to review the global meningitis situation and assess efforts made in meningitis prevention and control.

WHA73.10 Global actions on epilepsy and other neurological disorders¹

The Seventy-third World Health Assembly,

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

Recognizing that epilepsy and other neurological disorders are the leading cause of disability-adjusted life years and the second leading cause of death worldwide, and that epilepsy and other neurological disorders have a disproportionate impact on people living in low- and middle-income countries;³

Noting that neurological disorders are conditions of the central and peripheral nervous system that include epilepsy, headache disorders, neurodegenerative disorders, cerebrovascular diseases including stroke, neuroinfectious and/or neuroimmunological disorders, neurodevelopmental disorders and traumatic brain and spinal cord injuries;²

Noting also, with concern, that the risk of premature death in people with epilepsy is three times higher than in the general population and that, over the past 30 years, the absolute number of deaths due to neurological disorders has increased by 39%;⁴

Acknowledging, as outlined in the WHO, International League Against Epilepsy and International Bureau for Epilepsy global report, *Epilepsy: a public health imperative*,⁴ published in 2019, that epilepsy is one of the most common neurological disorders globally, affecting an estimated 50 million people worldwide across all ages, with increased rates in people who are young and those who are old;

Recognizing that epilepsy is a highly treatable condition and that over 70% of people with epilepsy could live seizure-free if they had access to appropriate anti-seizure treatment,⁴ the most cost-effective of which are included in the WHO Model List of Essential Medicines;

Recalling resolution WHA67.22 (2014) on access to essential medicines, in which the Health Assembly called for action to enhance access to essential medicines, and urged Member States, inter alia, to identify key barriers to access to essential medicines;

Noting that, despite the low cost of effective interventions for epilepsy (estimated at less than US\$ 5 per person per year), the current treatment gap is over 75% in most low-income countries and 50% in the majority of middle-income countries, and that lack of access to medicines and other effective interventions, and to specialist consultations, coupled with discrimination and stigma associated with this condition, is resulting in disability, mortality, social exclusion, economic disadvantage and negative mental health outcomes in people living with epilepsy; and noting further that tackling epilepsy is widely considered to be a public health imperative, as concluded in the 2019 global report *Epilepsy: a public health imperative*;

¹ See Annex 3 for the financial and administrative implications for the Secretariat of this resolution.

² Document A73/5.

³ As per the 2016 Global Burden of Disease Study (Global, regional, and national burden of neurological disorders, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet Neurol.* 2019;18(5):459-480. doi: 10.1016/S1474-4422(18)30499-X. Epub 2019 Mar 14).

⁴ *Epilepsy: a public health imperative*. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/325293>, accessed 4 January 2021).

Recognizing that approximately 25% of epilepsy cases and a significant proportion of other neurological disorders could be prevented if broader public health actions were taken to strengthen maternal and newborn health care, ensure effective noncommunicable disease control (including promotion of cerebrovascular health and prevention of traumatic brain injuries, as well as prevention of central nervous system infections), and to expand scientific research and training of health professionals;

Acknowledging the importance of addressing the preventable causes of epilepsy and other neurological disorders, including by: promoting healthy brain development and functioning over the life course;¹ the control of neurocysticercosis and its association with epilepsy;² the provision of safe environments to avoid traumatic injuries due to accidents, violence or exposure to environmental pollutants;² and access to medicines to prevent neurological infections, such as tetanus, rabies, HIV-associated neurological disorders and cerebral malaria;³

Recognizing that epilepsy and other neurological disorders often co-exist and can be compounded by other health conditions, that epilepsy, for example, can occur following stroke and traumatic brain injury, that neurological disorders, including epilepsy, are commonly associated with infections such as malaria and meningitis, and that among people with intellectual disabilities one in four also lives with epilepsy; and noting that the WHO global disability action plan 2014–2021 and WHO’s global action plan on the public health response to dementia 2017–2025 provide useful frameworks for taking a synergistic and complementary approach to tackling some of these co-existing conditions;

Noting with concern the significant mental health impact of neurological disorders on affected persons and their families and recalling, therefore, the importance of resolution WHA66.8 (2013), through which the Health Assembly adopted the comprehensive mental health action plan 2013–2020;

Recalling United Nations General Assembly resolution 70/1 (2015) entitled “Transforming our world: the 2030 Agenda for Sustainable Development,” the outcome document of the United Nations Conference on Sustainable Development entitled “The future we want”,⁴ and the report of the Open Working Group of the General Assembly on Sustainable Development Goals,⁵ established pursuant to United Nations General Assembly resolution 66/288 (2012), which includes Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and target 3.4 (By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being);

Recalling also that in order to promote physical and mental health and well-being, and to extend life expectancy for all, we must achieve universal health coverage;

Recalling further that we are committed to the prevention and treatment of noncommunicable diseases, including behavioural, developmental and neurological disorders, which constitute a major challenge for sustainable development;

¹ See resolution WHA67.10 (2014) on the newborn health action plan; and resolution WHA57.17 (2004) on the global strategy on diet, physical activity and health.

² See Accelerating work to overcome the global impact of neglected tropical diseases: a roadmap for implementation. Geneva: World Health Organization; 2012 (<https://apps.who.int/iris/handle/10665/338712>, accessed 28 January 2021).

³ The global health sector strategy on HIV (2016–2021); the global technical strategy for malaria (2016–2030); and decision EB146(6) (2020) on meningitis prevention and control.

⁴ United Nations General Assembly resolution 66/288 (2012), Annex. The future we want. Outcome document of the United Nations Conference on Sustainable Development (Rio de Janeiro, Brazil, 20–22 June 2012).

⁵ United Nations General Assembly document A/68/970.

Recalling also the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases entitled “Time to deliver: accelerating our response to address non-communicable diseases for the health and well-being of present and future generations”, at which Heads of State and Government recognized that mental health, epilepsy and other neurological disorders are important causes of morbidity necessitating provision of equitable access to effective programmes and health-care interventions;

Reaffirming resolution WHA68.20 (2015) on the global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications, in which the Health Assembly urged Member States to address the global burden of epilepsy through eight categories of coordinated action and requested the Director-General to provide technical support to Member States in actions for epilepsy management, especially low- and middle-income countries;

Acknowledging that, given the high global disability and mortality burden associated with epilepsy and other neurological disorders, achieving universal health coverage and the Sustainable Development Goals will not be possible without concerted intersectoral efforts to address the needs of people at risk of, or living with, epilepsy or other neurological disorders;

Recognizing, therefore, the urgent need for an intersectoral public health approach to epilepsy and other neurological disorders that places the needs of affected people at the centre, and which emphasizes the critical role of tackling disease risk factors, primary health care, health system strengthening and sustainable access to affordable essential medicines in line with resolutions WHA62.12 (2009) on primary health care, including health system strengthening, WHA67.22 (2014) on access to essential medicines and WHA72.2 (2019) on primary health care;

Welcoming, therefore, the reports contained in documents EB146/12, A71/41 Rev.2 and A73/5, which build on the achievements of WHO, the International League Against Epilepsy and the International Bureau for Epilepsy in raising awareness and advocating action for epilepsy through the “Out of the shadows” global campaign,¹ and through International Epilepsy Day; and further welcoming the ongoing work, in response to decision EB146(8) (2020) on epilepsy, to develop technical guidance (including in respect of health system strengthening and addressing the risk factors for disease) on strengthening country actions against epilepsy and its comorbidities;

Recognizing that, given the challenges of discrimination and stigma associated with neurological disorders and, in particular, epilepsy, innovative strategies are also needed to strengthen international efforts and national leadership to support policies and laws for persons living with epilepsy and other neurological disorders, while fully respecting their human rights;

Reiterating additionally the multidimensional nature of epilepsy and other neurological disorders and, thus, the need for effective intersectoral partnerships and action plans that involve all stakeholders, including, though not limited to, health, social care, the education and employment sectors, civil society and people living with neurological disorders and their families;

Acknowledging the critical importance of adequate public financing to address the significant and often catastrophic out-of-pocket health- and social-care expenditures experienced by people living with epilepsy and/or other neurological disorders;

Noting the need for explicit incorporation into national budgets of funding costs to support the implementation of evidence-based, intersectoral plans of actions as well as ongoing research into

¹ Global campaign against epilepsy: out of the shadows. Geneva: World Health Organization; 2003 (https://www.who.int/mental_health/management/en/GcaeBroEn.pdf?ua=1, accessed 12 November 2020).

effective prevention, detection, treatment, care and rehabilitation, including treatment options with the potential to cure epilepsy and other neurological disorders,

1. URGES Member States¹ to provide the appropriate support to the Organization to develop the intersectoral global action plan on epilepsy and other neurological disorders referenced in paragraph 3(1) below;

2. CALLS UPON all relevant stakeholders to provide appropriate support to WHO and partners to develop the intersectoral global action plan on epilepsy and other neurological disorders referred to in paragraph 3(1) below;

3. REQUESTS the Director-General:

(1) to develop, in consultation with Member States,¹ and in full collaboration with other organizations of the United Nations system and relevant non-State actors, a 10-year intersectoral global action plan on epilepsy and other neurological disorders in support of universal health coverage to address the current significant gaps in promotion of physical and mental health, and prevention, early detection, care, treatment and rehabilitation, as well as the social, economic, educational and inclusion needs of persons and families living with epilepsy and other neurological disorders, and the ongoing need for research to improve prevention, early detection, treatment, care and rehabilitation, including treatment options with the potential to cure epilepsy and other neurological disorders;

(2) to include in the intersectoral global action plan ambitious, but achievable, global targets on reducing preventable cases of, and avoidable deaths resulting from, epilepsy and other neurological disorders, strengthening service coverage and access to essential medicines, improving surveillance and critical research and addressing stigmatization and discrimination;

(3) to submit a draft intersectoral global action plan for consideration by the Executive Board at its 150th session, together with a report on the progress achieved in implementing this resolution, with the intention of submitting the draft action plan to the Seventy-fifth World Health Assembly for endorsement.

(Third plenary meeting, resumed session, 13 November 2020 –
Committee A, second report)

¹ And, where applicable, regional economic integration organizations.

DECISIONS

WHA73(1) Election of officers of the Seventy-third World Health Assembly

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

President:	Ms Keva Bain (Bahamas)
Vice-Presidents:	Mrs Jacqueline Lydia Mikolo (Congo) Mr Roberto Ciavatta (San Marino) Dr Viroj Tangcharoensathien (Thailand) H.E. Mr LI Song (China) Dr Akram Eltoum (Sudan)

(First plenary meeting, 18 May 2020)

WHA73(2) Special procedures

The Seventy-third World Health Assembly, having considered the report on special procedures,¹ decided:

- (1) to adopt the special procedures to regulate the conduct of virtual *de minimis* meetings of the World Health Assembly set out in the Annex to this decision;
- (2) that the said special procedures shall apply to the meetings of the Health Assembly opening on 18 May 2020 and closing no later than 19 May 2020.

ANNEX

SPECIAL PROCEDURES TO REGULATE THE CONDUCT OF VIRTUAL *DE MINIMIS* MEETINGS OF THE HEALTH ASSEMBLY

RULES OF PROCEDURE OF THE WORLD HEALTH ASSEMBLY

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

¹ Document A73/33.

Procedure to the extent necessary in accordance with Rule 122 of the Rules of Procedure of the World Health Assembly.¹

ATTENDANCE AND QUORUM

2. Attendance by Member States, Associate Members, Observers, invited representatives of the United Nations and of other participating intergovernmental organizations shall be through a secured access to videoconference or other electronic means allowing representatives to hear other participants and to address the meeting remotely.
3. Attendance by non-State actors in official relations with WHO shall be through electronic means allowing representatives to hear other participants.
4. For the avoidance of doubt, virtual attendance of Members shall be taken into account when calculating the presence of a quorum.

ADDRESSING THE HEALTH ASSEMBLY

5. Member States and Associate Members, as well as Observers, invited representatives of the United Nations and other participating intergovernmental organizations, and non-State actors in official relations with WHO are invited to submit written statements of no more than 600 words in one of the official languages of the Organization for posting on the WHO website under the item on coronavirus disease (COVID-19) in advance of the opening of the Seventy-third World Health Assembly.
6. The Heads of Member State and Associate Member delegations shall also have the opportunity, if they so wish to submit pre-recorded video statements of no more than two minutes in duration in advance of the opening of the session, if possible, by Friday, 15 May 2020 at 18:00 (CET). Those video statements will be broadcast at the virtual meeting in lieu of a live intervention under the item on COVID-19.
7. Written statements, in the language of submission, and video statements so submitted shall form part of the official records of the session.
8. During the virtual session, only Member States, Associate Members, Observers and invited representatives of the United Nations and of other participating intergovernmental organizations shall be provided with the opportunity to take the floor. Individual statements will be limited to two minutes and regional and group statements will be limited to four minutes.
9. Any Member wishing to take the floor should signal their wish to speak. Any Member wishing to raise a point of order or exercise a right of reply in relation to an oral or pre-recorded statement made

¹ This will affect notably the relevant provisions of the following Rules of Procedure of the World Health Assembly as they appear in the 49th edition of *Basic documents*:

- Rule 24, Rules 30–42 and Rule 51 (Committee on Credentials, General Committee, main committees and subcommittees), as well as the relevant provisions of Rule 13 and Rules 44–48 insofar as they refer to these committees;
- Rule 49 (formal proposals for items on the agenda);
- Rules 73, 78–79 and 81–86 (voting by show of hands and secret ballot);
- Rules 101–105 (process for nominating and electing Members entitled to designate a person to serve on the Board by secret ballot);
- Rule 121 (amendments and additions to the Rules of Procedure) insofar as these special procedures may be regarded as additions to the Rules of Procedure and to the extent that Rule 121 requires receipt and consideration of a report thereon by an appropriate committee.

at the virtual Health Assembly should signal their intention to do so. It is understood that, in accordance with well-established practice, any right of reply to an oral or pre-recorded statement made at the virtual meeting shall be exercised at the end of the virtual meeting. Any Member wishing to exercise a right of reply in relation to a written statement should do it in writing as soon as possible and, in any case, no later than 10 working days after the suspension and/or closure of the relevant virtual session. Statements so submitted shall form part of the official records of the meeting in the language of submission.

COMMITTEES

10. All business shall be conducted in plenary. Accordingly, the General Committee, main committees and Committee on Credentials shall not be established. Matters normally determined by the General Committee under Rule 32 shall be determined by the plenary. Credentials shall be considered as set out below.

REGISTRATION AND CREDENTIALS

11. Online registration will follow normal practice. Additional information is provided in the related Circular Letter.

12. In accordance with Rule 23, the names of representatives, which in the case of Members and Associate Members shall take the form of credentials, shall be communicated electronically to the Director-General if possible no later than 14 May 2020. Given the need to facilitate virtual access to the meeting, all credentials and lists of representatives should be submitted electronically.

13. The President and Vice-Presidents of the Seventy-second World Health Assembly having assessed, before the opening of the Seventy-third session, whether credentials of Members and Associate Members are in conformity with the requirements of the Rules of Procedure, shall report to the Health Assembly accordingly during the opening with a view to the Health Assembly making a decision thereon.

14. The President and Vice-Presidents of the Seventy-third World Health Assembly shall be invited, before the opening of a resumed session, to assess whether new or revised credentials of Members and Associate Members are in conformity with the requirements of the Rules of Procedure and shall report to the Health Assembly accordingly during the opening of a resumed session with a view to the Health Assembly making a decision thereon.

MEETINGS

15. All meetings of the Health Assembly shall be held in public. The virtual Health Assembly shall be broadcast on the WHO website, in line with usual practice.

SUBMISSION OF FORMAL PROPOSALS FOR THE RESUMED SESSION

16. The first day of the resumed session of the Health Assembly shall be regarded as the first day of the session for the purposes of Rule 49, by which date formal proposals relating to items of the agenda may be introduced.

DECISION-MAKING

17. All decisions of the Health Assembly taken in virtual meetings should as far as possible be taken by consensus. In any event, given the virtual nature of the meeting, no decision shall be taken by show

of hands vote or by secret ballot. In the event of a roll-call vote, and in line with normal practice, should any delegate fail to cast a vote for any reason during the roll-call, that delegate shall be called upon a second time after the conclusion of the initial roll-call. Should the delegate fail to cast a vote on the second roll-call, the delegation shall be recorded as absent.

18. Brief statements consisting in explanation of votes may, if not made orally, be submitted in writing no later than three working days following the suspension and/or closure of the relevant virtual session. Statements so submitted shall form part of the official records of the meeting in the language of submission.

ELECTION OF MEMBERS ENTITLED TO DESIGNATE A PERSON TO SERVE ON THE EXECUTIVE BOARD

19. In accordance with the well-established practice of the Health Assembly by which Members entitled to designate a person to serve on the Executive Board are elected by acclamation under Rule 80 following nominations made by the six regions, the President shall propose to the Health Assembly to proceed without taking a ballot on an agreed list of candidates reflecting the nominations made by the six regions, provided that:

(a) the list of nominations shall have been made available to all delegations at least three days in advance of the opening of the Health Assembly; and

(b) no Member State shall have informed the Director-General of an objection to the list of nominations within two days of the list of nominations having been made available unless such objection was subsequently withdrawn by the Member State concerned.

20. In the event that the virtual meeting of the Health Assembly is suspended with a view to being resumed at a later date, the date of suspension of the virtual meeting shall be regarded as the closing of the session solely for the purposes of ascertaining the beginning and end of the terms of office of each Member entitled to designate a person to serve on the Executive Board under Rule 105.

LANGUAGES

21. For the avoidance of doubt, Rule 88 shall continue to apply, whereby speeches made in an official language shall be interpreted into the other official languages.

(First plenary meeting, 18 May 2020)

WHA73(3) Verification of credentials

The Seventy-third World Health Assembly accepted the credentials presented by the following 190 Member States as being in conformity with the Rules of Procedure of the World Health Assembly: Afghanistan; Albania; Algeria; Andorra; Angola; Antigua and Barbuda; Argentina; Armenia; Australia; Austria; Azerbaijan; Bahamas; Bahrain; Bangladesh; Barbados; Belarus; Belgium; Belize; Benin; Bhutan; Bolivia (Plurinational State of); Bosnia and Herzegovina; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cabo Verde; Cambodia; Cameroon; Canada; Central African Republic; Chad; Chile; China; Colombia; 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; Dominica; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Eritrea; Estonia; Eswatini; Ethiopia; Fiji; Finland; France; Gabon; Gambia; Georgia; Germany; Ghana; Greece; Grenada; Guatemala; Guinea; Guyana; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica;

Japan; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Kyrgyzstan; Lao People's Democratic Republic; Latvia; Lebanon; Lesotho; Liberia; Libya; Lithuania; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; Marshall Islands; Mauritania; Mauritius; Mexico; Micronesia (Federated States of); Monaco; Mongolia; Montenegro; Morocco; Mozambique; Myanmar; Namibia; Nauru; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; North Macedonia; Norway; Oman; Pakistan; Palau; Panama; 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; Spain; Sri Lanka; Sudan; Suriname; Sweden; Switzerland; Syrian Arab Republic; Tajikistan; Thailand; Timor-Leste; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Turkmenistan; Tuvalu; Uganda; Ukraine; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; Uzbekistan; Vanuatu; Venezuela (Bolivarian Republic of); Viet Nam; Yemen; Zambia; Zimbabwe.

(First plenary meeting, 18 May 2020)

WHA73(4) Adoption of the agendas

The Seventy-third World Health Assembly adopted the provisional agenda prepared by the Executive Board at its 146th session and the provisional agenda (abridged) contained in document A73/1 Add. 1 and decided to defer consideration of the proposal for a supplementary item to a resumed session.

(First plenary meeting, 18 May 2020)

WHA73(5) Election of Members entitled to designate a person to serve on the Executive Board

The Seventy-third World Health Assembly, in accordance with the special procedures,¹ elected the following as Members entitled to designate a person to serve on the Executive Board: Botswana, Colombia, Ghana, Guinea-Bissau, India, Madagascar, Oman, Republic of Korea, Russian Federation, United Kingdom of Great Britain and Northern Ireland.

(Second plenary meeting, 19 May 2020)

WHA73(6) Selection of the country in which the Seventy-fourth World Health Assembly would be held

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

(Second plenary meeting, 19 May 2020)

¹ Decision WHA73(2).

WHA73(7) Written silence procedure

The Seventy-third World Health Assembly, having considered the report on the closure of the Health Assembly: written silence procedure,¹ decided:

- (1) to adopt the written silence procedure set out in the Annex to this decision;
- (2) to suspend Rule 49 of the Rules of Procedure of the World Health Assembly in respect of the deadline for introduction of formal proposals for the purposes of paragraph 1 of the written silence procedure.

ANNEX**WRITTEN SILENCE PROCEDURE**

1. Following the suspension of the Seventy-third World Health Assembly session and pending its resumption, the following written silence procedure will apply in respect of any proposal that the President of the Health Assembly determines, following informal consultations or because the proposal was recommended by the Executive Board for adoption, is suitable for adoption without further discussion by the Health Assembly.
2. At the request of the President of the Health Assembly, the Director-General will transmit to Member States any such proposal for consideration under this written silence procedure.
3. The communication will contain the text of the proposal(s) to be considered under this written silence procedure and will set a date for the receipt of any objection. Any such objection is to be conveyed in writing and addressed to the Director-General. The date for receipt of any objection will be 14 days from the date of dispatch of the communication.
4. In absence of the receipt by the set date of any written objection from a Member State, the proposal concerned will be considered as having been validly adopted by the Health Assembly. The adopted proposal will be referred to the Health Assembly at its resumed session for information only.
5. In the event of the receipt by the set date of one or more written objections from a Member State, the proposal concerned will be considered as having not been adopted by the Health Assembly. The proposal concerned will be referred to the Health Assembly for consideration at its resumed session.
6. The Director-General will communicate the outcome of the written silence procedure to all Member States as soon as possible after the set date referred to in paragraph 3. In the case of a proposal that is adopted pursuant to the written silence procedure, the date of the Director-General's communication to that effect will be date of adoption of the proposal.
7. Without prejudice to the above, any Member State may explain its position in respect of a proposal that is subject to the written silence procedure by submitting a written statement relating thereto, for posting on the WHO website. Written statements should be received by the Director-General by the date set for receipt of objections under paragraph 3. Written statements will be made available on the WHO website for information purposes only. They will appear as submitted and in the language(s) of submission. Submission of a written statement in accordance with this paragraph will not be considered as an objection for the purposes of paragraphs 3 to 5.

(Second plenary meeting, 19 May 2020)

¹ Document A73/35.

WHA73(8) Suspension of the session

The Seventy-third World Health Assembly, having considered the report on the suspension of the session,¹ decided:

- (1) that the Seventy-third session shall be suspended and shall resume at such date and either in Geneva or through such means as to be decided by the Executive Board or, exceptionally, by the Officers of the Executive Board in consultation with the Director-General;
- (2) that all items that have not been considered at the virtual Seventy-third session between its opening on 18 May 2020 and its suspension no later than 19 May 2020 will be considered by the Health Assembly at its resumed Seventy-third session, including any item in respect of which a proposal has been considered under the written silence procedure;²
- (3) that the date of suspension of the virtual Seventy-third session will be regarded as the closing of the session for the purposes of ascertaining the beginning and end of the terms of office of the Members entitled to designate a person to serve on the Board in accordance with Rule 105 of the Rules of Procedure of the World Health Assembly.

(Second plenary meeting, 19 May 2020)

WHA73(9) Immunization Agenda 2030

The Seventy-third World Health Assembly, having adopted the written silence procedure through decision WHA73(7) (2020),³ decided:

- (1) to endorse the new global vision and overarching strategy for vaccines and immunization: Immunization Agenda 2030;⁴
- (2) to request the Director-General:
 - (a) to finalize the operational elements outlined in the Immunization Agenda 2030, in consultation with Member States and other relevant stakeholders, for consideration by the Seventy-fourth World Health Assembly, through the Executive Board at its 148th session;
 - (b) to continue to monitor progress and to report biennially as a substantive agenda item to the Health Assembly, through the Executive Board, on the achievements made in advancing towards the global goals of the Immunization Agenda 2030, starting with the Seventy-fifth World Health Assembly.

(C.L.31.2020, 3 August 2020)

¹ Document A73/34.

² Decision WHA73(7).

³ See also document A73/7.

⁴ Immunization Agenda 2030: a global strategy to leave no one behind. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/m/item/immunization-agenda-2030-a-global-strategy-to-leave-no-one-behind>, accessed 18 April 2021).

WHA73(10) Geneva buildings renovation strategy¹

The Seventy-third World Health Assembly, having adopted the written silence procedure through decision WHA73(7) (2020),² decided:

- (1) to reiterate its appreciation to the Swiss Confederation and to the Republic and Canton of Geneva for the continued expression of their hospitality;
- (2) to authorize the Director-General to proceed with the construction of two security buildings and a new facility for housing equipment for the district heating and cooling system at WHO headquarters in Geneva on the basis that the costs of both projects do not exceed the previously approved budget of the Geneva buildings renovation strategy;
- (3) to reiterate that if the likely total cost of the Geneva buildings renovation were to increase by more than 10% of the previously approved budget, further authority would be sought from the Health Assembly;
- (4) to request the Director-General to continue to report at least every two years to the Executive Board and the Health Assembly on progress made with the Geneva buildings renovation strategy and related construction costs until completion of the project.

(C.L.31.2020, 3 August 2020)

WHA73(11) Global strategy and plan of action on public health, innovation and intellectual property¹

The Seventy-third World Health Assembly, having adopted the written silence procedure through decision WHA73(7) (2020),² decided:

- (1) to urge Member States to reinforce the implementation, as appropriate and taking into account national contexts, of the recommendations of the review panel³ 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 reiterate the necessity for Member States to further discuss, in informal consultations to be convened by the Director-General in 2020, the recommendations of the review panel referred to in paragraph 2 of decision WHA71(9) (2018);
- (3) to call on Member States to further discuss, in informal consultations to be convened by the Director-General in 2020, the recommendations of the review panel on promoting and monitoring transparency of medicines prices and actions to prevent shortages;
- (4) to reiterate to the Director-General the necessity to allocate the necessary resources to implement the recommendations of the review panel addressed to the WHO Secretariat as prioritized by the review panel, consistent with the global strategy and plan of action on public health, innovation and intellectual property in conformity with paragraph 3 of decision WHA71(9);

¹ See Annex 3 for the financial and administrative implications for the Secretariat of this decision.

² See also document A73/4.

³ See document WHA71/2018/REC/1, Annex 5.

(5) to further request the Director-General to submit a report on progress made in implementing this decision, including the results of the consultations referred to in paragraphs 2 and 3, to the Seventy-fourth World Health Assembly in 2021, through the Executive Board at its 148th session, as a substantive agenda item.

(C.L.31.2020, 3 August 2020)

WHA73(12) Decade of Healthy Ageing 2020–2030¹

The Seventy-third World Health Assembly, having adopted the written silence procedure through decision WHA73(7) (2020),² decided:

- (1) to endorse the proposal for a Decade of Healthy Ageing 2020–2030;
- (2) to request the Director-General:
 - (a) to report back on progress in the implementation of the Decade of Healthy Ageing 2020–2030 to the Seventy-sixth World Health Assembly, the Seventy-ninth World Health Assembly and the Eighty-second World Health Assembly;
 - (b) to transmit this decision to the Secretary-General of the United Nations for the consideration of the proposal for a Decade of Healthy Ageing 2020–2030 by the United Nations General Assembly, as appropriate.

(C.L.31.2020, 3 August 2020)

WHA73(13) WHO reform: travel and other entitlements of the Chair of the Executive Board and other Board members

The Seventy-third World Health Assembly, having adopted the written silence procedure through decision WHA73(7) (2020),³ and recalling resolutions WHA30.10 (1977) and WHA55.22 (2002), decided:

- (1) that, with effect from 1 July 2020, the maximum reimbursement of travel expenses of the Chair of the Executive Board shall be based on the travel entitlements for the WHO Director-General;
- (2) to request the Director-General to prepare a report on the entitlements of members of the Executive Board, for consideration by the Executive Board at its 147th session.

(C.L.31.2020, 3 August 2020)

¹ See Annex 3 for the financial and administrative implications for the Secretariat of this decision.

² See also document A73/5.

³ See also document A73/18.

WHA73(14) Influenza preparedness¹

The Seventy-third World Health Assembly, having adopted the written silence procedure through decision WHA73(7) (2020),² decided:

- (1) to note the release of WHO's Global Influenza Strategy 2019–2030,³ and its linkages to the implementation of the International Health Regulations (2005) and the Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits;
- (2) to request the Director-General:
 - (a) to support Member States, upon their request, to develop or update national influenza preparedness plans, and to consider implementing an annual influenza vaccination programme for target populations, taking into account, as relevant and appropriate to national circumstances, the goals and strategic objectives of WHO's Global Influenza Strategy 2019–2030;
 - (b) to promote timely access to, and distribution of, quality, safe, effective and affordable seasonal influenza vaccines, diagnostics, and treatments;
 - (c) to continue to engage Member States and all relevant stakeholders to promote and uphold the Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits, and to encourage international collaboration for the rapid, systematic, and timely sharing of influenza viruses with human pandemic potential, and equitable and timely access to quality, safe, effective and affordable pandemic influenza vaccines, diagnostics and therapeutics, and other benefits, on an equal footing;
 - (d) to prioritize and contribute to international efforts to sustain and enhance influenza surveillance through WHO's Global Influenza Surveillance and Response System (GISRS), by continuing to work with Member States, GISRS laboratories, and other relevant stakeholders, to:
 - (i) gather and share information, voluntarily provided, about influenza virus-sharing and its associated benefits; and
 - (ii) encourage countries to voluntarily share information and best practices on mitigating hinderances to the rapid, systematic, and timely international sharing of seasonal and pandemic influenza biological materials and to its associated benefits;
 - (e) to promote synergies, as relevant and appropriate, between and among, efforts to implement: national plans for influenza preparedness and response; the International Health Regulations (2005); and immunization programmes;
 - (f) to consult Member States and relevant stakeholders, including manufacturers, in a manner consistent with WHO's Framework of Engagement with Non-State Actors, to

¹ See Annex 3 for the financial and administrative implications for the Secretariat of this decision.

² See also document A73/4.

³ Global influenza strategy 2019–2030. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/311184>, accessed 14 April 2021).

identify gaps in, and priorities for, affordable, scalable and sustainable global influenza vaccine production capacity, supply chains and distribution networks;

(g) to report on implementation of this decision to the Seventy-fifth World Health Assembly, through the Executive Board at its 150th session.

(C.L.31.2020, 3 August 2020)

WHA73(15) WHO reform: governance¹

The Seventy-third World Health Assembly, having adopted the written silence procedure through decision WHA73(7) (2020),² decided:

(1) that comments and inputs on global strategies, policies and legal instruments such as conventions, regulations and codes, made in line with decision WHA65(9) (2012) on WHO reform, may be understood to include those provided by Member States in the context of technical meetings, informal consultations and other intergovernmental meetings in the regions;

(2) to request that the Director-General systematically include as substantive items on the agendas of meetings of the WHO governing bodies any global strategies or action plans that are scheduled to expire within one year in order to allow Member States to consider whether global strategies or action plans have fulfilled their mandates, should be extended and/or need to be adjusted.

(C.L.31.2020, 3 August 2020)

WHA73(16) Evaluation of the election of the Director-General of the World Health Organization¹

The Seventy-third World Health Assembly, having adopted the written silence procedure through decision WHA73(7) (2020),³ decided:

(1) to continue conducting the appointment of the Director-General by means of a paper-based secret ballot vote as currently provided for in the Rules of Procedure of the World Health Assembly;

(2) that in future, the beginning of the Director-General's contract be set for mid-August of the year of appointment, to lengthen the transition period between the appointment of the Director-General by the Health Assembly in May and her or his taking office, and that the contract of the incumbent Director-General be amended accordingly.

(C.L.31.2020, 3 August 2020)

¹ See Annex 3 for the financial and administrative implications for the Secretariat of this decision.

² See also document A73/4.

³ See also document A73/20.

WHA73(17) Election of officers of the Seventy-third World Health Assembly (resumed)¹

The Seventy-third World Health Assembly elected the following officer:

Vice-President: H.E. Dr Osama Ahmed Abdelrahim (Sudan)

(First plenary meeting, resumed session, 9 November 2020)

WHA73(18) Special procedures for the conduct of the Seventy-third World Health Assembly (resumed)

The Seventy-third World Health Assembly, having considered the report on special procedures,² decided to adopt the special procedures set out in the Annex to this decision to regulate the conduct of virtual meetings of the Seventy-third World Health Assembly (resumed), opening on 9 November 2020 and closing no later than 14 November 2020.

ANNEX**SPECIAL PROCEDURES TO REGULATE THE CONDUCT OF VIRTUAL MEETINGS OF THE SEVENTY-THIRD WORLD HEALTH ASSEMBLY (RESUMED)****RULES OF PROCEDURE**

1. The Rules of Procedure of the Health Assembly shall continue to apply in full, except to the extent that they are inconsistent with these special procedures, in which case the Health Assembly's decision to adopt these special procedures shall operate as a decision to suspend the relevant Rules of Procedure to the extent necessary in accordance with Rule 122 of the Rules of Procedure of the Health Assembly.³

ATTENDANCE

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

¹ See also decision WHA73(1).

² Document A73/42.

³ This will affect notably the relevant provisions of the following Rules of Procedure of the World Health Assembly as they appear in the 49th edition of the Basic Documents:

- Rule 49 (formal proposals for items on the agenda);
- Rules 73, 78–79 and 81 through 86 (voting by show of hands and secret ballot);
- Rule 121 (amendments and additions to the Rules of Procedure) insofar as these Special Procedures may be regarded as additions to the Rules of Procedure and to the extent that Rule 121 requires receipt and consideration of a report thereon by an appropriate committee.

QUORUM

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

ADDRESSING THE HEALTH ASSEMBLY

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

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

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

COMMITTEES

7. The General Committee, the Committee on Credentials and the Main Committees of the Health Assembly shall be established. The Committee on Credentials shall meet only in the event that a matter is referred to it by the Health Assembly or by the President of the Health Assembly.

REGISTRATION AND CREDENTIALS

8. The Health Assembly accepted the credentials presented by the 190 Member States listed in decision WHA73(3) as being in conformity with the Rules of Procedure of the World Health Assembly. Those credentials remain valid for the resumed meetings of the Health Assembly taking place from 9 to 14 November 2020.

9. Nonetheless, for the sole purpose of registration, credentials already submitted by Member States for the meeting in May 2020 must be re-submitted through the WHO online registration system for the resumed meetings in November 2020.

10. If a Member State wishes to modify the composition of its delegation, credentials submitted during registration should reflect such changes. This may take the form either of supplemental credentials or of new credentials indicating the revised composition of the full delegation. In line with past practice, changes to the composition of a delegation will not normally require a decision of the Health Assembly thereon.

11. Member States not among those listed in decision WHA73(3) shall submit credentials in accordance with Rule 23 at the time of registration. Those credentials shall be reviewed by the President and Vice-Presidents of the Seventy-third World Health Assembly, before the opening of the resumed meeting of the Seventy-third session, in order to assess their conformity with the Rules of Procedure and to report to the Health Assembly thereon.

12. All credentials shall be communicated electronically to the Director-General through the WHO online registration system, if possible, no later than 4 November 2020.

SUBMISSION OF FORMAL PROPOSALS FOR THE RESUMED SESSION

13. The first day of the resumed session of the Health Assembly shall be regarded as the first day of the session for the purposes of Rule 49, by which date formal proposals relating items of the agenda may be introduced.

DECISION-MAKING

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

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

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

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

(First plenary meeting, resumed session, 9 November 2020)

WHA73(19) Composition of the Committee on Credentials

The Seventy-third World Health Assembly appointed a Committee on Credentials consisting of delegates of the following Member States: Bulgaria, El Salvador, Japan, Liberia, Mozambique, North Macedonia, Republic of Moldova, Rwanda, Somalia, Timor-Leste, Trinidad and Tobago and Viet Nam.

(First plenary meeting, resumed session, 9 November 2020)

WHA73(20) Election of officers of the main committees

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

Committee A:	Chairman	Dr Bjørn-Inge Larsen (Norway)
Committee B:	Chairman	H.E. Mr Mamadou Henri Konate (Mali)

(First plenary meeting, resumed session, 9 November 2020)

The main committees subsequently elected the following officers:

Committee A:	Vice-Chairmen	Ms Tamara Mawhinney (Canada) Dr Susie Perera De Silva (Sri Lanka)
	Rapporteur	Dr Jane Ruth Aceng Ocerro (Uganda)

Committee B: Vice-Chairmen Dr Ahmad Jawad Osmani (Afghanistan)
H.E. Mrs Elizabeth Wilde (Australia)
Mr Amadou Thiam (Mali) *ad interim*

Rapporteur Mr Tashi Penjor (Bhutan)

(First meetings of Committees A and B,
9 November 2020)

WHA73(21) Establishment of the General Committee

The Seventy-third World Health Assembly elected the delegates of the following 17 countries as members of the General Committee: Argentina, Croatia, Cuba, Djibouti, Eritrea, Ethiopia, Fiji, France, Mongolia, Nepal, Nicaragua, Oman, Russian Federation, Sierra Leone, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, United States of America.

(First plenary meeting, resumed session, 9 November 2020)

WHA73(22) Verification of credentials for the Seventy-third World Health Assembly (resumed)

Further to decision WHA73(3), the Seventy-third World Health Assembly accepted the credentials presented by the following three Member States as being in conformity with the Rules of Procedure of the World Health Assembly: Guinea-Bissau, Samoa and South Sudan.

(Second and third plenary meetings, resumed session, 9 and 13 November 2020)

WHA73(23) Adoption of the agenda and allocation of items to the main committees

The Seventy-third World Health Assembly decided not to include a proposed supplementary agenda item.

(Second plenary meeting, resumed session, 9 November 2020)

WHA73(24) Report of the External Auditor

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

(Third plenary meeting, resumed session, 13 November 2020 –
Committee B, first report)

¹ Document A73/27.

² Document A73/39.

WHA73(25) Appointment of representatives to the WHO Staff Pension Committee

The Seventy-third World Health Assembly renewed Dr Alan Ludowyke of the delegation of Sri Lanka as a member and appointed him for a three-year term until the closure of the Seventy-sixth World Health Assembly in May 2023.

The Health Assembly appointed Dr Arthur Williams of the delegation of Sierra Leone, the most senior alternate, as a member of the WHO Staff Pension Committee for the remainder of his term of office until the closure of the Seventy-fifth World Health Assembly in May 2022.

The Health Assembly appointed Ms Yanjmaa Binderiya of the delegation of Mongolia as an alternate member of the WHO Staff Pension Committee for the remainder of the term of office of Dr Chieko Ikeda until the closure of the Seventy-fourth World Health Assembly in May 2021.

The Health Assembly appointed Dr Kai Zaehle of the delegation of Germany as an alternate member of the WHO Staff Pension Committee for the remainder of the term of office of Dr Christoph Hauschild until the closure of the Seventy-fourth Assembly in May 2021.

The Health Assembly appointed Dr Ahmed Shadoul of the delegation of Sudan as an alternate member of the WHO Staff Pension Committee for a three-year term until the closure of the Seventy-sixth World Health Assembly in May 2023.

(Third plenary meeting, resumed session, 13 November 2020
Committee B, first report)

WHA73(26) Maternal, infant and young child nutrition¹

The Seventy-third World Health Assembly, having considered the reports on maternal, infant and young child nutrition,² and recalling the mandates given in resolutions and decisions on: the International Code of Marketing Breastmilk Substitutes (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), WHA58.32 (2005), WHA59.21 (2006), WHA61.20 (2008) and WHA63.23 (2010)); the WHO/UNICEF Global Strategy for infant and young child feeding (WHA55.25 (2002)); the WHO Global Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition (WHA65.6 (2012)); maternal, infant and young child nutrition: development of the core set of indicators (WHA68(14)); ending inappropriate promotion of foods for infants and young children (WHA69.9 (2016) and WHA71.9 (2018)); and ending childhood obesity (WHA69(12) (2016) and WHA70(19) (2017)), decided to request the Director-General:

- (1) to streamline future reporting requirements on maternal, infant and young child nutrition, through biennial reports to the Health Assembly, through the Executive Board, until 2030 (to be issued in 2022, 2024, 2026, 2028 and 2030, respectively);

¹ See Annex 3 for the financial and administrative implications for the Secretariat of this decision.

² Documents A73/4 (section 15.2) and A73/4 Add.2.

- (2) to review current evidence and prepare a comprehensive report to understand the scope and impact of digital marketing strategies for the promotion of breast-milk substitutes to the Seventy-fifth World Health Assembly in 2022, through the Executive Board.

(Third plenary meeting, resumed session, 13 November 2020
Committee B, first report)

WHA73(27) Evaluation of the election of the Director-General of the World Health Organization: amendments to Annexes 1 and 2 to resolution WHA66.18 (2013)¹

The Seventy-third World Health Assembly, having considered the report of the Chairperson of the informal consultations on the evaluation of the election of the Director-General of the World Health Organization;² having also considered the Chair's summary and proposed way forward regarding the informal consultations;³ taking into account the discussions at the 146th session of the Executive Board;⁴ and having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-third World Health Assembly,⁵ decided to adopt the amendments to Annexes 1 and 2 to resolution WHA66.18 (2013) on the code of conduct for the election of the Director-General of the World Health Organization and the candidates' forum, respectively, as set out in Annex 2.

(Third plenary meeting, resumed session, 13 November 2020)

WHA73(28) Global strategy on digital health¹

The Seventy-third World Health Assembly, having considered the consolidated report by the Director-General⁶ and the draft global strategy on digital health,⁷ decided:

- (1) to endorse the global strategy on digital health;
- (2) to request the Director-General to report back on progress in the implementation of the global strategy on digital health to the Seventy-sixth World Health Assembly in 2023.

(Third plenary meeting, resumed session, 13 November 2020
Committee B, first report)

¹ See Annex 3 for the financial and administrative implications for the Secretariat of this decision.

² Document EB146/39.

³ Document A73/20 Add.1.

⁴ See the summary records of the Executive Board at its 146th session, fourteenth meeting, section 6, and fifteenth meeting, section 1.

⁵ Document A73/41.

⁶ Documents A73/4, item 18.6.

⁷ Global strategy on digital health. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/344249>, accessed 1 October 2021).

WHA73(29) WHO programmatic and financial report for 2018–2019, including audited financial statements for 2019

The Seventy-third World Health Assembly, having considered the WHO Results Report for the Programme budget 2018–2019 and the audited financial statements for the year ended 31 December 2019;¹ and having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-third World Health Assembly,² decided to accept the WHO Results Report for the Programme budget 2018–2019 and the audited financial statements for the year ended 31 December 2019.

(Third plenary meeting, resumed session, 13 November 2020
Committee B, second report)

WHA73(30) Human resources for health³

The Seventy-third World Health Assembly, having considered the report by the Director-General,⁴ together with the report of the WHO Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel;⁵ acknowledging also the synergies with the global agenda on nursing and midwifery in the International Year of the Nurse and the Midwife, and the role of health and care workers at the forefront of the fight against the pandemic of coronavirus disease (COVID-19), decided:

- (1) to commend the successful conclusion of the work of the WHO Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel, the leadership of its Co-Chairs, and the dedication of its distinguished members;
- (2) to note the report of the WHO Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel;
- (3) to encourage Member States and all relevant stakeholders to implement the recommendations of the WHO Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel;²
- (4) to request that a WHO Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel conduct a further assessment of the Code's relevance and effectiveness following the fifth round of national reporting in 2023–2024, with a report thereon to be submitted for consideration by the Seventy-ninth World Health Assembly, through the Executive Board at its 158th session;
- (5) to acknowledge the tireless efforts of health and care workers in response to the COVID-19 pandemic and designate 2021 as the International Year of Health and Care Workers;

¹ Documents A73/24, A73/25 and A73/INF./3.

² Document A73/37.

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

⁴ Document A73/9.

⁵ Document A73/9, Annex.

(6) to request the Director-General:

(a) to promote effective implementation of the recommendations of the WHO Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel;

(b) to engage WHO at all levels, with Member States and other relevant stakeholders, in making best use of the International Year of Health and Care Workers to advance progress on Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages);

(c) to engage with all WHO regions to update the *Global Strategic Directions for Nursing and Midwifery 2016–2020*¹ and, following consultations with Member States, submit this update to the Seventy-fourth World Health Assembly for its consideration.

(Third plenary meeting resumed session, 13 November 2020
Committee B, second report)

WHA73(31) 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-third World Health Assembly decided to defer a decision on the status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution, to the Seventy-fourth World Health Assembly, on the understanding that the Health Assembly would take up this matter on the basis of a report providing an update on the situation and supplying any pertinent additional information, by the Executive Board, through the Programme, Budget and Administration Committee.

(Third plenary meeting, resumed session, 13 November 2020
Committee B, second report)

WHA73(32) Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan²

The Seventy-third World Health Assembly, having considered the report by the Director-General,³ decided to request the Director-General:

(1) to report on progress made in the implementation of the recommendations contained in the report by the Director-General,³ based on field monitoring, to the Seventy-fourth 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;

¹ Global strategic directions for strengthening nursing and midwifery 2016–2020. Geneva: World Health Organization; 2016 (<https://apps.who.int/iris/handle/10665/275453>, accessed 15 April 2021).

² See Annex 3 for the financial and administrative implications for the Secretariat of this decision.

³ Document A73/15.

- (3) to ensure sustainable procurement of WHO prequalified vaccines and medicine and medical equipment to the occupied Palestinian territory in compliance with international humanitarian law and WHO norms and standards;
- (4) to continue strengthening partnerships with other United Nations entities and partners in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, to enhance humanitarian health response capacities by delivering aid and protection in an inclusive and sustained manner during the pandemic of coronavirus disease (COVID-19) and after the pandemic crisis;
- (5) to provide health-related technical support to the Syrian population in the occupied Syrian Golan;
- (6) to continue providing the necessary technical support 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;
- (7) 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, and by decreasing referrals, reducing cost, strengthening provision of mental health services and maintaining strong primary health care with integrated complete appropriate health services;
- (8) to ensure the allocation of human and financial resources in order to achieve these objectives.

(Third plenary meeting, resumed session, 13 November 2020
Committee B, third report)

WHA73(33) Road map for neglected tropical diseases 2021–2030¹

The Seventy-third World Health Assembly, having considered the report on neglected tropical diseases,² and recalling resolution WHA66.12 (2013) on neglected tropical diseases, WHO's road map for accelerating work to overcome the global impact of neglected tropical diseases (2012–2020), and Member States' commitment to Sustainable Development Goal target 3.3 (by 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases), decided:

- (1) to endorse, and urge Member States to implement, the new road map for neglected tropical diseases 2021–2030, "Ending the neglect to attain the Sustainable Development Goals: a road map for neglected tropical diseases 2021–2030";³

¹ See Annex 3 for the financial and administrative implications for the Secretariat of this decision.

² Document A73/8.

³ Ending the neglect to attain the Sustainable Development Goals: a road map for neglected tropical diseases 2021–2030. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/338565>, accessed 15 April 2021).

(2) to request the Director-General:

(a) to advocate for, and provide technical support and guidance to Member States and partners in the implementation of, the new road map for neglected tropical diseases 2021–2030 towards reaching Sustainable Development Goal target 3.3;

(b) to continue to monitor progress in the implementation of the road map and under a substantive agenda item, to report biennially to the Health Assembly, through the Executive Board, on the implementation of the road map for neglected tropical diseases 2021–2030, starting at the Seventy-fifth World Health Assembly until the Seventy-ninth World Health Assembly, and then from the Eighty-second World Health Assembly to the Eighty-fourth World Health Assembly.

(Third plenary meeting, resumed session, 13 November 2020
Committee A, second report)

ANNEXES

ANNEX 1

Amended Contract of the Director-General¹

THIS CONTRACT is made this twenty-third day of May of the year two thousand and seventeen between the World Health Organization (hereinafter called the Organization) of the one part and Dr Tedros Adhanom Ghebreyesus (hereinafter called the Director-General) of the other part.

WHEREAS

(1) It is provided by Article 31 of the Constitution of the Organization that the Director-General of the Organization shall be appointed by the World Health Assembly (hereinafter called the Health Assembly) on the nomination of the Executive Board (hereinafter called the Board) on such terms as the Health Assembly may decide; and

(2) The Director-General has been duly appointed by the Health Assembly at its meeting held on the twenty-third day of May of the year two thousand and seventeen for a period of five years.

NOW THIS CONTRACT WITNESSETH and it is hereby agreed as follows,

I. (1) The Director-General shall serve from the first day of July of the year two thousand and seventeen until the fifteenth day of August of the year two thousand and twenty-two, on which date the appointment and this Contract shall terminate.

(2) Subject to the authority of the Board, the Director-General shall exercise the functions of chief technical and administrative officer of the Organization and shall perform such duties as may be specified in the Constitution and in the rules of the Organization and/or as may be assigned to him or her by the Health Assembly or the Board.

(3) The Director-General fully commits to the responsible management and appropriate stewardship of WHO's resources, including financial resources, human resources and physical resources, in an efficient and effective manner to achieve the Organization's objectives; an ethical culture, so that all Secretariat decisions and actions are informed by accountability, transparency, integrity, and respect; equitable geographical representation and gender balance in staff appointments and in accordance with Article 35 of the Constitution of the World Health Organization; follow-up of recommendations from the Organization's internal and external audits, and timeliness and transparency of official documentation.

(4) The Director-General shall be subject to the Staff Regulations of the Organization in so far as they may be applicable to him. In particular he shall not hold any other administrative post, and shall not receive emoluments from any outside sources in respect of activities relating to the Organization. He shall not engage in business or in any employment or activity that would interfere with his duties in the Organization.

¹ See resolution WHA73.6, decision WHA72(17), resolution WHA70.3 and documents WHA72/2019/REC/1, Annex 6 and WHA70/2017/REC/1, Annex 1.

(5) The Director-General, during the term of this appointment, shall enjoy all the privileges and immunities in keeping with the office by virtue of the Constitution of the Organization and any relevant arrangements already in force or to be concluded in the future.

(6) The Director-General may at any time give six months' notice of resignation in writing to the Board, which is authorized to accept such resignation on behalf of the Health Assembly; in which case, upon the expiration of the said period of notice, the Director-General shall cease to hold the appointment and this Contract shall terminate.

(7) The Health Assembly shall have the right, on the proposal of the Board and after hearing the Director-General and subject to at least six months' notice in writing, to terminate this Contract for reasons of exceptional gravity likely to prejudice the interests of the Organization.

II. (1) As from the first day of July of the year two thousand and seventeen the Director-General shall receive from the Organization an annual salary of two hundred and forty-one thousand, two hundred and seventy-six United States dollars, before staff assessment, resulting in a net salary (to be paid monthly) of one hundred and seventy-two thousand, and sixty-nine United States dollars per annum or its equivalent in such other currency as may be mutually agreed between the parties to this Contract.

(2) In addition to the normal adjustments and allowances authorized to staff members under the Staff Rules, the Director-General shall receive an annual representation allowance of twenty-one thousand United States dollars or its equivalent in such other currency as may be mutually agreed between the parties to this Contract, to be paid monthly commencing on the first day of July of the year two thousand and seventeen. The representation allowance shall be used at his discretion entirely in respect of representation in connection with his official duties. He shall be entitled to such reimbursable allowances as travel allowances and removal costs on appointment, on subsequent change of official station, on termination of appointment, or on official travel and home leave travel.

(3) The Director-General shall participate in and contribute to the United Nations Joint Staff Pension Fund in accordance with the Regulations and Rules of the United Nations Joint Staff Pension Fund for the term of his appointment.

III. The terms of the present Contract relating to rates of salary and representation allowance are subject to review and adjustment by the Health Assembly, on the proposal of the Board and after consultation with the Director-General, in order to bring them into conformity with any provision regarding the conditions of employment of staff members which the Health Assembly may decide to apply to staff members already in the service.

IV. If any question of interpretation or any dispute arises concerning this Contract that is not settled by negotiation or agreement, the matter shall be referred for final decision to the competent tribunal provided for in the Staff Rules.

WHEREUNTO we have set our hands the day and year first above written.

.....

Dr Tedros Adhanom Ghebreyesus
Director-General

.....

Professor Veronika Skvortsova
President of the Seventieth
World Health Assembly

ANNEX 2

Code of conduct for the election of the Director-General of the World Health Organization¹

CODE OF CONDUCT

In resolution WHA65.15 concerning the report of the Working Group of Member States on the Process and Methods of the Election of the Director-General of the World Health Organization, the World Health Assembly decided, inter alia, that “a code of conduct, in line with Recommendation 7 of the report of the Joint Inspection Unit “Selection and Conditions of Service of Executive Heads in the United Nations System Organizations”, which candidates for the post of Director-General of the World Health Organization and Member States should undertake to observe and respect, will be developed by the Secretariat for consideration by the Sixty-sixth World Health Assembly through the Executive Board.”

This code of conduct (the “code”) aims at promoting an open, fair, equitable and transparent process for the election of the Director-General of the World Health Organization. In seeking to improve the overall process, the code addresses several areas, including the submission of proposals, the conduct of electoral campaigns by Member States and candidates, as well as funding and financial matters.

The code is a political understanding reached by the Member States of the World Health Organization. It recommends desirable behaviour by Member States and candidates with regard to the election of the Director-General in order to increase the fairness, credibility, openness and transparency of the process and thus its legitimacy as well as the legitimacy and acceptance of its outcome. As such, the code is not legally binding but Member States and candidates are expected to honour its contents.

A. General requirements

I. Basic principles

The whole election process as well as electoral campaign activities related to it should be guided by the following principles that further the legitimacy of the process and of its result:

due regard to the principle of equitable geographical representation,
fairness,
equity,
transparency,
good faith,
dignity, mutual respect and moderation,
non-discrimination, and
merit.

¹ See decision WHA73(27).

II. Authority of the Health Assembly and the Executive Board in accordance with their Rules of Procedure

1. Member States accept the authority of the Health Assembly and the Executive Board to conduct the election of the Director-General in accordance with their Rules of Procedure and relevant resolutions and decisions.
2. Member States that propose persons for the post of Director-General have the right to promote those candidatures. The same applies to candidates with regard to their own candidature. In the exercise of that right, Member States and candidates should abide by all rules governing the election of the Director-General contained in the Constitution of the World Health Organization, the Rules of Procedure of the World Health Assembly, and the Rules of Procedure of the Executive Board as well as in relevant resolutions and decisions.

III. Responsibilities

1. It is the responsibility of Member States and candidates for the post of Director-General of the World Health Organization to observe and respect this code.
2. Member States acknowledge that the process of election of the Director-General should be fair, open, transparent, equitable and based on the merits of the individual candidates. They should make this code publicly known and easily accessible.
3. The Secretariat will also promote awareness of the code in accordance with the provisions of the code.

B. Requirements for the different steps of the election process**I. Submission of proposals**

When proposing the name of one or more persons for the post of Director-General, Member States should include in their proposal a statement to the effect that they and the persons proposed by them pledge to observe the provisions of the code. The Director-General will remind Member States accordingly when inviting Member States to propose persons for the post of Director-General in accordance with Rule 62 of the Rules of Procedure of the Executive Board.

II. Electoral campaign

1. This code applies to electoral campaign activities related to the election of the Director-General whenever they take place until the appointment by the Health Assembly.
2. All Member States and candidates should encourage and promote communication and cooperation among one another during the entire election process. Member States and candidates should act in good faith bearing in mind the shared objectives of promoting equity, openness, transparency and fairness throughout the election process.
3. All Member States and candidates should promptly disclose their campaign activities (for example, hosting of meetings, workshops and visits), together with the amount and source of all funding for campaign activities, and communicate them to the Secretariat. Information so disclosed will be posted on a dedicated page of the WHO website.

4. Member States and candidates should refer to one another with respect; no Member State or candidate should at any time disrupt or impede the campaign activities of other candidates. Nor should any Member State or any candidate make any oral or written statement or other representation that could be deemed slanderous or libellous.
5. Member States and candidates should refrain from improperly influencing the election process, by, for example, granting or accepting financial or other benefits as a quid pro quo for the support of a candidate, or by promising such benefits.
6. Member States and candidates should not make promises or commitments in favour of, or accept instructions from, any person or entity, public or private, and should avoid any other similar action, when that could undermine, or be perceived as undermining, the integrity of the election process.
7. Member States proposing persons for the post of Director-General should promptly disclose grants or aid funding to other Member States during the previous two years in order to ensure full transparency and mutual confidence among Member States.
8. Member States that have proposed persons for the post of Director-General should facilitate meetings between their candidate and other Member States, if so requested. Wherever possible, meetings between candidates and Member States should be arranged on the occasion of conferences or other events involving different Member States rather than through bilateral visits.
9. Travel by candidates to Member States to promote their candidature should be limited in order to avoid excessive expenditure that could lead to inequality among Member States and candidates. In this connection, Member States and candidates should consider using as much as possible existing mechanisms (sessions of the regional committees, Executive Board and Health Assembly) for meetings and other promotional activities linked to the electoral campaign.
10. Candidates, whether internal or external, should not combine their official travel with campaigning activities. Electoral promotion or propaganda under the guise of technical meetings or similar events should be avoided. It is understood, however, that candidates for the post of Director-General on official travel may participate in the web forum, the candidates' forums and in campaign activities on the margins of regional committee sessions.
11. After the Director-General has dispatched all proposals, curricula vitae and supporting information to Member States in accordance with Rule 62 of the Rules of Procedure of the Executive Board, the Secretariat will open on the WHO website a password-protected forum for questions and answers, open to all Member States and candidates. Such a forum will not be held in the case of only one candidate being proposed. The Secretariat will also post on the WHO website information on all candidates who so request including their curricula vitae and other particulars of their qualifications and experience as received from Member States within the deadline provided in the second paragraph of Rule 62 of the Rules of Procedure of the Executive Board as well as their contact information. The website will also provide links to individual websites of candidates upon request. Each candidate is responsible for setting up and financing his or her own website.
12. The Secretariat will also post on WHO's website, at the time referred to in the first paragraph of Rule 62 of the Rules of Procedure of the Executive Board, information on the election process and the applicable rules and decisions, as well as the text of this code.

III. Nomination and appointment

1. The nomination and appointment of the Director-General is conducted by the Executive Board and the Health Assembly, respectively, in accordance with their Rules of Procedure and relevant resolutions and decisions. As a matter of principle in order to preserve the serenity of the proceedings, candidates should not attend those meetings even if they form part of the delegation of a Member State.
2. Member States should abide strictly by the Rules of Procedure of the Executive Board and of the World Health Assembly and other applicable resolutions and decisions and respect the integrity, legitimacy and dignity of the proceedings. As such, they should avoid behaviours and actions, both inside and outside the conference room where the nomination and appointment take place, that could be perceived as aiming at influencing its outcome.
3. Member States should respect the confidentiality of the proceedings and the secrecy of the votes. In particular, they should refrain from communicating or broadcasting the proceedings during the private meetings through electronic devices.
4. In view of the secret nature of the vote for the nomination and appointment of the Director-General, Member States should refrain from publicly announcing in advance their intention to vote for a particular candidate.

IV. Internal candidates

1. WHO staff members, including the Director-General in office, who are proposed for the post of Director-General, are subject to the obligations contained in the WHO Constitution, Staff Regulations and Staff Rules as well as to the guidance that may be issued from time to time by the Director-General.
2. WHO staff members who are proposed for the post of Director-General must observe the highest standard of ethical conduct and strive to avoid any appearance of impropriety. WHO staff members must clearly separate their WHO functions from their candidacy and avoid any overlap, or perception of overlap, between campaign activities and their work for WHO. They also have to avoid any perception of conflict of interest.
3. WHO staff members are subject to the authority of the Director-General, in accordance with the applicable regulations and rules, in case of allegations of breach of their duties with regard to their campaign activities.
4. The Health Assembly or the Executive Board may call upon the Director-General to apply Staff Rule 650 concerning special leave to staff members who have been proposed for the post of Director-General.

CANDIDATES' FORUMS

Convening and conduct of the forum

1. Two candidates' forums will be convened by the Secretariat at the request of the Executive Board as self-standing events: one preceding the session of the Board at which candidates will be nominated for the post of Director-General and one prior to the session of the Health Assembly at which the appointment will take place. Both candidates' forums will be chaired by the Chairman of the Board, with the support of the Officers of the Executive Board. The Board will decide the dates of the forums at the session preceding the session at which the nomination will take place.

Timing

2. The candidates' forums shall be held not later than two months in advance of the sessions of the Board and the Health Assembly at which the nomination and appointment will take place, respectively.

Duration

3. The duration of the candidates' forums will be decided by the Officers of the Board depending on the number of candidates. Notwithstanding the foregoing, the maximum duration of the forums shall be three days each.

Format

4. The first candidates' forum will consist of interviews with the candidates. Each candidate shall make a presentation of up to 10 minutes, which will be followed by a question-and-answer session so that the overall duration of each interview shall be 60 minutes. The order of the interviews shall be determined by lot.

4bis. The second candidates' forum will consist of a more interactive panel discussion between the candidates and Member States and Associate Members attending the forum.

5. Further detailed arrangements for the interviews may be decided either by the Board at its session preceding the event or by the Member States and Associate Members attending the forum upon the proposal of the Chair of the Board.

Participation

6. Participation in the candidates' forums will be limited to Member States¹ and Associate Members of the World Health Organization.

7. The candidates' forums will be broadcast by the Secretariat through a link on the WHO website accessible to the public.

Documentation

8. The curricula vitae of candidates and other supporting information provided in line with Rule 62 of the Rules of Procedure of the Board within the deadline set out in the second paragraph thereof will be made available electronically to all Member States and Associate Members in the WHO official languages.

¹ And, where applicable, regional economic integration organizations.

ANNEX 3

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

Resolution WHA73.1	COVID-19 response
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this resolution would contribute:	For 2020, WHO's work on COVID-19 is primarily covered by WHO's Strategic Preparedness and Response Plan, which is implemented in the outbreak and crisis response ¹ budget segment for which outputs are not defined in the approved Programme budget 2020–2021. Beyond 2020, the Organization's COVID-19-related work may affect a large number of the existing Programme budget 2020–2021 outputs; a corporate review to better defining the implications across all outputs and levels of the Organization is in process.
2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	There was no provision for the work of this resolution in the approved Programme budget 2020–2021; the work described is considered to be additional to the outbreak and crisis response segment of the budget.
4. Estimated time frame (in years or months) to implement the resolution:	WHO's Strategic Preparedness and Response Plan covers 2020 only; the full impact of the resolution will stretch over several bienniums. At the time of writing, the full time frame for the Strategic Preparedness and Response Plan is being defined on the basis of continuous review, given the rapidly evolving nature of the situation, but is expected to last until at least 2021.
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	The budget for 2020 is US\$ 1740 million as per WHO's Strategic Preparedness and Response Plan; due to the rapidly evolving situation of the pandemic, no budget estimates are currently available beyond 2020.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	No provision for the work of WHO's Strategic Preparedness and Response Plan was made in the approved Programme budget 2020–2021.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 1740 million for 2020. The budget for 2021 is not yet confirmed. Note that this would be implemented under the outbreak and crisis response segment of the approved Programme budget 2020–2021.

¹ Also referred to as emergency operations and appeals.

3. Estimated resource requirements to be considered for the proposed Programme budget for 2022–2023, in US\$ millions:
No budget estimate for 2022–2023 is yet available.
4. Estimated resource requirements to be considered for the proposed Programme budgets of future bienniums, in US\$ millions:
No budget estimate for future bienniums is yet available.
5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions
– Resources available to fund the resolution in the current biennium: Donor agreements for a total of US\$ 819 million have been concluded. – Remaining financing gap in the current biennium: The remaining funding gap for WHO's Strategic Preparedness and Response Plan for 2020 is US\$ 921 million. – Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium: Resource mobilization activities and COVID-19 WHO appeal are in process.

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

Biennium	Costs	Region						Headquarters (including global research and development)	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 additional resources	Staff	90	45	20	21	32	24	133	365
	Activities	360	155	155	154	283	201	67	1375
	Total	450	200	175	175	315	225	200	1740
2022–2023 resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
Future bienniums resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–

^a Due to the rapidly evolving situation of the pandemic, no budget estimates are currently available beyond 2020. Those for 2020 are outlined in WHO's Strategic Preparedness and Response Plan.

Resolution WHA73.2	Global strategy to accelerate the elimination of cervical cancer as a public health problem and its associated goals and targets for the period 2020–2030
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this resolution would contribute: 1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages 1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results 1.3.2. Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems 4.2.1. Leadership, governance and external relations enhanced to implement GPW 13 and drive impact in an aligned manner at the country level, on the basis of strategic communications and in accordance with the Sustainable Development Goals in the context of United Nations reform	
2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2020–2021: Not applicable.	
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021: Zero.	
4. Estimated time frame (in years or months) to implement the resolution: June 2020 to December 2030.	
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions: US\$ 162.1 million.	
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions: US\$ 19.9 million: US\$ 11.1 million for staff, US\$ 8.8 million for activities.	
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions: Zero.	
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions: US\$ 32.5 million: US\$ 15.1 million for staff, US\$ 17.4 million for activities.	
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions: For future bienniums, until the end of 2030: a total of US\$ 109.7 million (US\$ 48.6 million for staff, US\$ 61.1 million for activities).	

- 5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions**
- **Resources available to fund the resolution in the current biennium:**
US\$ 16.6 million.
 - **Remaining financing gap in the current biennium:**
US\$ 3.3 million.
 - **Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:**
Zero.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	3.1	0.5	0.2	0.3	0.3	0.6	6.1	11.1
	Activities	2.0	0.5	0.4	0.4	0.3	0.7	4.5	8.8
	Total	5.1	1.0	0.6	0.7	0.6	1.3	10.6	19.9
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	4.6	0.9	0.5	0.7	0.6	0.9	6.9	15.1
	Activities	5.6	2.2	0.6	0.8	0.5	2.2	5.5	17.4
	Total	10.2	3.1	1.1	1.5	1.1	3.1	12.4	32.5
Future bienniums resources to be planned	Staff	16.1	3.3	2.4	3.1	2.7	3.3	17.7	48.6
	Activities	20.9	7.7	3.0	3.7	3.0	7.8	15.0	61.1
	Total	37.0	11.0	5.4	6.8	5.7	11.1	32.7	109.7

Resolution WHA73.3	Global strategy for tuberculosis research and innovation
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this resolution would contribute:	1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages 1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results 1.3.4. Research and development agenda defined and research coordinated in line with public health priorities
2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Not applicable.

4. Estimated time frame (in years or months) to implement the resolution:	10 years, consistent with the WHO End TB Strategy and the United Nations Sustainable Development Goals.
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	US\$ 12.62 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 2.33 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Not applicable.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	US\$ 2.42 million.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:	US\$ 7.87 million.
5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions	– Resources available to fund the resolution in the current biennium: US\$ 1.8 million. – Remaining financing gap in the current biennium: US\$ 0.53 million. – Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium: US\$ 0.53 million, based on current projections.

Resolution WHA73.4	Integrated people-centred eye care, including preventable vision impairment and blindness
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this resolution would contribute:	1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results 1.1.3. Countries enabled to strengthen their health systems to address population-specific health needs and barriers to equity across the life course 1.1.5. Countries enabled to strengthen their health workforce 1.2.3. Countries enabled to improve institutional capacity for transparent decision-making in priority-setting and resource allocation and analysis of the impact of health in the national economy

2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Staff would be needed to carry out technical work. Meetings of experts would also be organized.
4. Estimated time frame (in years or months) to implement the resolution:	Six years.
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	Biennium 2020–2021: US\$ 8.0 million Biennium 2022–2023: US\$ 8.0 million Biennium 2024–2025: US\$ 8.7 million Total cost: US\$ 24.7 million over six years
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 2.0 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	An additional investment of US\$ 6.0 million would be required for the extra work needed, assuming full financing and implementation during 2020–2021. This contingency level would be applied as necessary to ensure full implementation of the objectives mandated by this resolution.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	US\$ 8.0 million.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:	Biennium 2024–2025: US\$ 8.7 million.
5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions	– Resources available to fund the resolution in the current biennium: US\$ 2.0 million. – Remaining financing gap in the current biennium: US\$ 6.0 million. – Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium: On course to raise US\$ 3.0 million in the current biennium and there are ongoing efforts to raise an additional US\$ 3.0 million.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	–	–	–	–	–	–	1.0	1.0
	Activities	–	–	–	–	–	–	1.0	1.0
	Total	–	–	–	–	–	–	2.0	2.0
2020–2021 additional resources	Staff	0.6	0.2	0.4	0.2	0.4	0.6	0.0	2.4
	Activities	0.9	0.3	0.6	0.3	0.6	0.9	0.0	3.6
	Total	1.5	0.5	1.0	0.5	1.0	1.5	0.0	6.0
2022–2023 resources to be planned	Staff	0.6	0.2	0.4	0.2	0.4	0.6	1.0	3.4
	Activities	0.9	0.3	0.6	0.3	0.6	0.9	1.0	4.6
	Total	1.5	0.5	1.0	0.5	1.0	1.5	2.0	8.0
Future bienniums resources to be planned	Staff	0.7	0.2	0.4	0.2	0.4	0.7	1.1	3.7
	Activities	0.9	0.3	0.7	0.3	0.7	1.0	1.1	5.0
	Total	1.6	0.5	1.1	0.5	1.1	1.7	2.2	8.7

Resolution WHA73.5 Strengthening efforts on food safety	
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this resolution would contribute:	2.1.3. Countries operationally ready to assess and manage identified risks and vulnerabilities 2.3.1. Potential health emergencies rapidly detected, and risks assessed and communicated 3.1.2. Countries enabled to address environmental determinants of health, including climate change 3.2.1. Countries enabled to develop and implement technical packages to address risk factors through multisectoral action 3.3.2. Global and regional governance mechanisms used to address health determinants and multisectoral risks
2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	In adopting this resolution to strengthen efforts on food safety, the Executive Board would approve a commitment by the Organization to deliver the outputs already planned for, but also to scale up the associated work in updating the WHO global strategy for food safety: safer food for better health and in developing the growth, capacity and usage of food safety infrastructure around the world. The scale of the work involved was not fully appreciated at the time when the Programme budget 2020–2021 was approved, which is why additional work would need to be planned for here.
4. Estimated time frame (in years or months) to implement the resolution:	Six years.
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	US\$ 24.7 million.

2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 3.1 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 5.4 million.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	US\$ 8.1 million.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:	US\$ 8.1 million.
5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions	
– Resources available to fund the resolution in the current biennium:	US\$ 3.1 million.
– Remaining financing gap in the current biennium:	US\$ 5.4 million.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:	
	Discussions are in progress with the European Commission, the United States Food and Drug Administration, Canada and Japan on potential provision of support for food safety activities.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	–	–	–	–	–	–	0.5	0.5
	Activities	–	–	–	–	–	–	2.6	2.6
	Total	–	–	–	–	–	–	3.1	3.1
2020–2021 additional resources	Staff	0.1	0.03	0.1	0.03	0.1	0.1	1.4	1.9
	Activities	0.3	0.05	0.3	0.05	0.2	0.2	2.4	3.5
	Total	0.4	0.08	0.4	0.08	0.3	0.3	3.8	5.4
2022–2023 resources to be planned	Staff	0.1	0.1	0.1	0.1	0.1	0.1	1.9	2.5
	Activities	0.4	0.1	0.4	0.1	0.3	0.3	4.0	5.6
	Total	0.5	0.2	0.5	0.2	0.4	0.4	5.9	8.1
Future bienniums resources to be planned	Staff	0.1	0.1	0.1	0.1	0.1	0.1	1.9	2.5
	Activities	0.4	0.1	0.4	0.1	0.3	0.3	4.0	5.6
	Total	0.5	0.2	0.5	0.2	0.4	0.4	5.9	8.1

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

Resolution WHA73.6	Evaluation of the election of the Director-General of the World Health Organization: amendments to contract
Decision WHA73(27)	Evaluation of the election of the Director-General of the World Health Organization: amendments to Annexes 1 and 2 to resolution WHA66.18 (2013)
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which the resolution and decision would contribute:	4.2.1. Leadership, governance and external relations enhanced to implement GPW 13 and drive impact in an aligned manner at the country level, on the basis of strategic communications and in accordance with the Sustainable Development Goals in the context of United Nations reform
2. Short justification for considering the resolution and decision, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Not applicable.
4. Estimated time frame (in years or months) to implement the resolution and decision:	14 months (April 2021–June 2022).
B. Resource implications for the Secretariat for implementation of the resolution and decision	
1. Total resource requirements to implement the resolution and decision, in US\$ millions:	US\$ 0.49 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 0.41 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Zero.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	US\$ 0.08 million.
4. Estimated resource requirements to be considered for the programme budgets of future bienniums, in US\$ millions:	Zero.

5. **Level of available resources to fund the implementation of the resolution and decision in the current biennium, in US\$ millions**
- **Resources available to fund the resolution and decision in the current biennium:**
US\$ 0.41 million.
 - **Remaining financing gap in the current biennium:**
Zero.
 - **Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:**
Zero.

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

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	–	–	–	–	–	–	0.04	0.04
	Activities	–	–	–	–	–	–	0.37	0.37
	Total	–	–	–	–	–	–	0.41	0.41
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	–	–	–	–	–	–	0.00	0.00
	Activities	–	–	–	–	–	–	0.08	0.08
	Total	–	–	–	–	–	–	0.08	0.08
Future bienniums resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–

Resolution WHA73.7 Salaries of staff in ungraded positions and of the Director-General

A. Link to the approved Programme budget 2020–2021

1. **Output(s) in the approved Programme budget 2020–2021 to which this resolution would contribute:**
4.3.2. Effective and efficient management and development of human resources to attract, recruit and retain talent for successful programme delivery.
2. **Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2020–2021:**
Not applicable.
3. **Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:**
Not applicable.

4. Estimated time frame (in years or months) to implement the resolution: The relevant adjustments in remuneration will take effect from 1 January 2020. There is no defined end date for implementation.
B. Resource implications for the Secretariat for implementation of the resolution
1. Total resource requirements to implement the resolution, in US\$ millions: The resource requirements are already included within what is planned under the approved Programme budget 2020–2021. Regarding modifications to staff salaries, it should be noted that 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. These additional costs will be absorbed within the overall payroll budget fluctuations and post cost averages.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions: Not applicable. 2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions: Not applicable.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions: Not applicable.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions: Not applicable.
5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions – Resources available to fund the resolution in the current biennium: - Not applicable. – Remaining financing gap in the current biennium: - Not applicable. – Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium: - Not applicable.

Resolution WHA73.8	Strengthening preparedness for health emergencies: implementation of the International Health Regulations (2005)
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this resolution would contribute: All outputs covered by Pillar 2 (One billion more people better protected from health emergencies): 2.1.1. All-hazards emergency preparedness capacities in countries assessed and reported 2.1.2. Capacities for emergency preparedness strengthened in all countries 2.1.3. Countries operationally ready to assess and manage identified risks and vulnerabilities 2.2.1. Research agendas, predictive models and innovative tools, products and interventions available for high-threat health hazards 2.2.2. Proven prevention strategies for priority pandemic-/epidemic-prone diseases implemented at scale 2.2.3. Mitigate the risk of the emergence and re-emergence of high-threat pathogens 2.2.4. Polio eradication and transition plans implemented in partnership with the Global Polio Eradication Initiative 2.3.1. Potential health emergencies rapidly detected, and risks assessed and communicated 2.3.2. Acute health emergencies rapidly responded to, leveraging relevant national and international capacities 2.3.3. Essential health services and systems maintained and strengthened in fragile, conflict and vulnerable settings	
2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2020–2021: Not applicable.	
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021: Not applicable.	
4. Estimated time frame (in years or months) to implement the resolution: 24 months.	
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions: Not applicable: the work required to implement this resolution essentially consists of WHO's work already approved in the Programme budget 2020–2021 under Pillar 2, guided further by the recommendations of the Executive Board.	
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions: Not applicable. 2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions: Not applicable.	
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions: Not applicable.	

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

Resolution WHA73.9	Global road map on defeating meningitis by 2030
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this resolution would contribute:	1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages 1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results 1.3.2. Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems 1.3.4. Research and development agenda defined and research coordinated in line with public health priorities 2.2.2. Proven prevention strategies for priority pandemic-/epidemic-prone diseases implemented at scale
2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Not applicable.
4. Estimated time frame (in years or months) to implement the resolution:	The time frame for implementation runs over 11 years (2020–2030) – it includes the finalization of the strategy (in 2020), with the full implementation starting in 2021.
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	US\$ 75.91 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 6.66 million.

2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:
Not applicable.
3. Estimated resource requirements to be considered for the proposed Programme budget for 2022–2023, in US\$ millions:
US\$ 13.89 million.
4. Estimated resource requirements to be considered for the proposed Programme budgets of future bienniums, in US\$ millions:
US\$ 55.36 million.
5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions
– Resources available to fund the resolution in the current biennium:
US\$ 4.18 million.
– Remaining financing gap in the current biennium:
US\$ 2.48 million.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:
Fundraising efforts are ongoing, but no source of funds has been formally committed yet to fund the gap in 2021.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	1.75	0.25	0.20	0.25	0.60	0.25	1.61	4.91
	Activities	0.30	0.15	0.15	0.15	0.15	0.15	0.70	1.75
	Total	2.05	0.40	0.35	0.40	0.75	0.40	2.31	6.66
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	2.03	0.51	0.41	0.51	1.02	0.51	1.76	6.75
	Activities	1.02	1.02	1.02	1.02	1.02	1.02	1.02	7.14
	Total	3.05	1.53	1.43	1.53	2.04	1.53	2.78	13.89
Future bienniums resources to be planned	Staff	8.13	2.03	1.63	2.03	4.06	2.03	7.03	26.94
	Activities	4.06	4.06	4.06	4.06	4.06	4.06	4.06	28.42
	Total	12.19	6.09	5.69	6.09	8.12	6.09	11.09	55.36

Resolution WHA73.10 Global actions on epilepsy and other neurological disorders**A. Link to the approved Programme budget 2020–2021**

- 1. Output(s) in the approved Programme budget 2020–2021 to which this resolution would contribute:**
 1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results

2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Not applicable.
4. Estimated time frame (in years or months) to implement the resolution:	Activities for development and implementation of the intersectoral global action plan for epilepsy and other neurological disorders (2022–2031) will be carried out during the next 11 years (2021–2031).
B. Resource implications for the Secretariat for implementation of the resolution	
1. Total resource requirements to implement the resolution, in US\$ millions:	US\$ 36.9 million. 2021 (current biennium): US\$ 0.7 million (staff US\$ 0.6 million, activities US\$ 0.1 million). 2022–2031: US\$ 36.2 million (staff US\$ 19.6 million, activities US\$ 16.6 million).
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 0.7 million, planned for in the approved Programme budget 2020–2021, for staff costs and activities for development of the action plan. Thus there are no additional requirements.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Not applicable.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	US\$ 8.2 million (staff US\$ 4.1 million, activities US\$ 4.1 million). At headquarters: one person (100% of one full-time equivalent) at grade P4; one person (100% of one full-time equivalent) at grade P3; one person (15% of one full-time equivalent) at grade P5, with international expertise in public health and neurology; and one person providing administrative support (25% of one full-time equivalent) at grade G5. At the regional level: one person with international expertise in public health and neurology who also has knowledge of the situation (needs and resources) in their region (100% of one full-time equivalent) at grade P4 in each region.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:	Headquarters Three persons with international expertise in public health and neurology: – one (100% of one full-time equivalent) at grade P4 – one (100% of one full-time equivalent) at grade P3 – one (15% of one full-time equivalent) at grade P5; One person providing administrative support (25% of one full-time equivalent) at grade G5.

Regional level

One person with international expertise in public health and neurology who also has knowledge of the situation (needs and resources) in their region (100% of one full-time equivalent) at grade P4 in each region.

Total costs (headquarters and regional level)

Biennium 2024–2025: US\$ 7.0 million (staff US\$ 3.9 million, activities US\$ 3.1 million)

Biennium 2026–2027: US\$ 7.0 million (staff US\$ 3.9 million, activities US\$ 3.1 million)

Biennium 2028–2029: US\$ 7.0 million (staff US\$ 3.9 million, activities US\$ 3.1 million)

Biennium 2030–2031: US\$ 7.0 million (staff US\$ 3.9 million, activities US\$ 3.1 million)

Total: US\$ 28 million (staff US\$ 15.5 million, activities US\$ 12.5 million) for the four bienniums.

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

– **Resources available to fund the resolution in the current biennium:**

US\$ 0.2 million.

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

US\$ 0.5 million.

– **Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:**

Not applicable.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	–	–	–	–	–	–	0.6	0.6
	Activities	–	–	–	–	–	–	0.1	0.1
	Total	–	–	–	–	–	–	0.7	0.7
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	0.5	0.5	0.4	0.5	0.4	0.4	1.4	4.1
	Activities	0.3	0.3	0.3	0.3	0.3	0.3	2.3	4.1
	Total	0.8	0.8	0.7	0.8	0.7	0.7	3.7	8.2
Future bienniums resources to be planned	Staff	2.0	2.1	1.6	1.9	1.6	1.8	4.5	15.5
	Activities	1.2	1.2	1.2	1.2	1.2	1.2	5.3	12.5
	Total	3.2	3.3	2.8	3.1	2.8	3.0	9.7	28.0

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

Decision WHA73(10) Geneva buildings renovation strategy	
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this decision would contribute:	Not applicable.
2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Renovation of the Geneva buildings is a long-term infrastructure project that is being planned and implemented outside the results framework of the approved Programme budget 2020–2021. It is not directly linked to the technical delivery of any individual programme budget per se.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Construction of two security buildings and a new facility for housing equipment for the district heating and cooling system at WHO headquarters in Geneva.
4. Estimated time frame (in years or months) to implement the decision:	12 months.
B. Resource implications for the Secretariat for implementation of the decision	
1. Total resource requirements to implement the decision, in US\$ millions:	US\$ 10 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Not applicable.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 10 million.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	Not applicable.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:	Not applicable.
5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions	
– Resources available to fund the decision in the current biennium:	US\$ 10 million (will be covered by the existing interest-free loan from the Swiss federal authorities for the construction of the new building).
– Remaining financing gap in the current biennium:	Not applicable.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:	Not applicable.

Decision WHA73(11) Global strategy and plan of action on public health, innovation and intellectual property	
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this decision would contribute:	1.3.1. Provision of authoritative guidance and standards on quality, safety and efficacy of health products, including through prequalification services, essential medicines and diagnostics lists. 1.3.2. Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems. 1.3.3. Country and regional regulatory capacity strengthened, and supply of quality-assured and safe health products improved. 1.3.4. Research and development agenda defined and research coordinated in line with public health priorities. 1.3.5. Countries enabled to address antimicrobial resistance through strengthened surveillance systems, laboratory capacity, infection prevention and control, awareness-raising and evidence-based policies and practices.
2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Consultations to be convened by the Director-General on the recommendations of an overall programme review panel not emanating from the global strategy and plan of action on public health, innovation and intellectual property. In addition, scaling up of implementation of the recommendations of the review panel addressed to the WHO Secretariat beyond those already approved in the Programme budget 2020–2021.
4. Estimated time frame (in years or months) to implement the decision:	Three years (2020–2022).
B. Resource implications for the Secretariat for implementation of the decision	
1. Total resource requirements to implement the decision, in US\$ millions:	US\$ 16.9 million for the period 2020–2022.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 8.7 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	An additional investment of US\$ 2.0 million would be required for the extra work needed, assuming full financing and implementation during 2020–2021. This contingency level would be applied as necessary to ensure full implementation of the objectives mandated by this decision.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	US\$ 6.2 million.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:	Zero.

- 5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions**
- **Resources available to fund the decision in the current biennium:**
US\$ 1.7 million.
 - **Remaining financing gap in the current biennium:**
US\$ 9.0 million.
 - **Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:**
Discussions are ongoing with Member States and other donors in order to mobilize additional resources.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	–	–	–	–	–	–	0.8	0.8
	Activities	–	–	–	–	–	–	7.9	7.9
	Total	–	–	–	–	–	–	8.7	8.7
2020–2021 additional resources	Staff	–	–	–	–	–	–	0.8	0.8
	Activities	–	–	–	–	–	–	1.2	1.2
	Total	–	–	–	–	–	–	2.0	2.0
2022–2023 resources to be planned	Staff	–	–	–	–	–	–	0.8	0.8
	Activities	–	–	–	–	–	–	5.4	5.4
	Total	–	–	–	–	–	–	6.2	6.2
Future bienniums resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–

Decision WHA73(12)

Decade of Healthy Ageing

A. Link to the approved Programme budget 2020–2021

1. Output(s) in the approved Programme budget 2020–2021 to which this decision would contribute:

- 1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages
- 1.1.3. Countries enabled to strengthen their health systems to address population-specific health needs and barriers to equity across the life course
- 3.1.1. Countries enabled to address social determinants of health across the life course
- 3.2.1. Countries enabled to develop and implement technical packages to address risk factors through multisectoral action
- 3.2.2. Multisectoral determinants and risk factors addressed through engagement with public and private sectors, as well as civil society
- 3.3.1. Countries enabled to adopt, review and revise laws, regulations and policies to create an enabling environment for healthy cities and villages, housing, schools and workplaces
- 4.1.2. GPW 13 impacts and outcomes, global and regional health trends, Sustainable Development Goals indicators, health inequalities and disaggregated data monitored

2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2020–2021:
Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:
Not applicable.
4. Estimated time frame (in years or months) to implement the decision:
Ten years: 2020–2030.
B. Resource implications for the Secretariat for implementation of the decision
1. Total resource requirements to implement the decision, in US\$ millions:
US\$ 161.8 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:
US\$ 21.9 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:
Not applicable.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:
US\$ 31.2 million.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:
US\$ 108.7 million.
5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions
– Resources available to fund the decision in the current biennium:
US\$ 6.1 million.
– Remaining financing gap in the current biennium:
US\$ 15.8 million.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:
A resource mobilization strategy is under development.

Decision WHA73(14) Influenza preparedness	
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this decision would contribute:	2.2.2. Proven prevention strategies for priority pandemic-/epidemic-prone diseases implemented at scale
2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Not applicable.
4. Estimated time frame (in years or months) to implement the decision:	24 months.
B. Resource implications for the Secretariat for implementation of the decision	
1. Total resource requirements to implement the decision, in US\$ millions:	US\$ 2.78 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 2.78 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Zero.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	Zero.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:	Zero.
5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions	
– Resources available to fund the decision in the current biennium:	Zero.
– Remaining financing gap in the current biennium:	US\$ 2.78 million.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:	The Secretariat is seeking to expand the donor base to raise the funds needed.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	–	–	–	–	–	–	–	–
	Activities	0.24	0.24	0.24	0.24	0.24	0.24	1.34	2.78
	Total	–	–	–	–	–	–	–	–
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
Future bienniums resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–

Decision WHA73(15) WHO reform: governance	
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this decision would contribute:	4.2.1. Leadership, governance and external relations enhanced to implement GPW 13 and drive impact in an aligned manner at the country level, on the basis of strategic communications and in accordance with the Sustainable Development Goals in the context of United Nations reform.
2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Not applicable.
4. Estimated time frame (in years or months) to implement the decision:	12 months.
B. Resource implications for the Secretariat for implementation of the decision	
1. Total resource requirements to implement the decision, in US\$ millions:	The decision can be implemented fully by existing staff. There are no additional resource requirements.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Not applicable.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Not applicable.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	Not applicable.

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

Decision WHA73(16)	Evaluation of the election of the Director-General of the World Health Organization
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this decision would contribute:	4.2.1. Leadership, governance and external relations enhanced to implement GPW 13 and drive impact in an aligned manner at the country level, on the basis of strategic communications and in accordance with the Sustainable Development Goals in the context of United Nations reform
2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Not applicable.
4. Estimated time frame (in years or months) to implement the decision:	30 months.
B. Resource implications for the Secretariat for implementation of the decision	
1. Total resource requirements to implement the decision, in US\$ millions:	US\$ 0.77 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 0.54 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Zero.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	US\$ 0.23 million.

4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:
Zero.
5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions
– Resources available to fund the decision in the current biennium:
US\$ 0.54 million.
– Remaining financing gap in the current biennium:
Zero.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:
Zero.

Decision WHA73(26)	Maternal, infant and young child nutrition
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this decision would contribute:	3.1.1. Countries enabled to address social determinants of health across the life course 3.2.1. Countries enabled to develop and implement technical packages to address risk factors through multisectoral action 3.3.2. Global and regional governance mechanisms used to address health determinants and multisectoral risks
2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Not applicable.
4. Estimated time frame (in years or months) to implement the decision:	Two years.
B. Resource implications for the Secretariat for implementation of the decision	
1. Total resource requirements to implement the decision, in US\$ millions:	US\$ 0.156 million.

2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 0.156 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Zero.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	Zero.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:	Zero.
5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions	
– Resources available to fund the decision in the current biennium:	US\$ 0.156 million.
– Remaining financing gap in the current biennium:	Zero.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:	Not applicable.

Decision WHA73(28)	Global strategy on digital health
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this decision would contribute:	4.1.3. Strengthened evidence base, prioritization and uptake of WHO generated norms and standards and improved research capacity and the ability to effectively and sustainably scale up innovations, including digital technology, in countries 4.3.3. Effective, innovative and secure digital platforms and services aligned with the needs of users, corporate functions, technical programmes and health emergencies operations
2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	The implementation of the strategy in a select set of countries is not covered by the approved Programme budget 2020–2021, hence the request for additional US\$ 12 million in the current biennium.
4. Estimated time frame (in years or months) to implement 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\$ 395.5 million for 2020–2025
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 48 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	An additional investment of US\$ 12.0 million would be required for the extra work needed, assuming full financing and implementation during 2020–2021. This contingency ceiling would be applied as necessary to ensure full implementation of the objectives mandated by this decision.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	US\$ 158.5 million (the amount is projected, based on increased activities at the country and regional levels).
4. Estimated resource requirements to be considered for the programme budgets of future bienniums, in US\$ millions:	US\$ 177 million (the amount is projected, based on increased activities at the country and regional levels).
5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions	
– Resources available to fund the decision in the current biennium:	US\$ 11.2 million.
– Remaining financing gap in the current biennium:	US\$ 48.8 million.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:	US\$ 48.8 million are not yet available; however, intense fundraising efforts are under way for the implementation of the global strategy on digital health.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	1.60	1.20	0.90	1.00	0.80	1.00	9.20	15.70
	Activities	5.30	4.00	4.00	4.00	4.00	4.00	7.00	32.30
	Total	6.90	5.20	4.90	5.00	4.80	5.00	16.20	48.00
2020–2021 additional resources	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Activities	2.00	1.00	1.50	1.50	1.00	2.00	3.00	12.00
	Total	2.00	1.00	1.50	1.50	1.00	2.00	3.00	12.00
2022–2023 resources to be planned	Staff	1.80	1.40	1.00	1.20	0.90	1.20	15.00	22.50
	Activities	23.00	17.50	17.50	17.50	17.50	23.00	20.00	136.00
	Total	24.80	18.90	18.50	18.70	18.40	24.20	35.00	158.50
Future bienniums resources to be planned	Staff	2.10	1.60	1.20	1.30	1.10	1.30	15.00	23.60
	Activities	26.50	20.10	20.10	20.10	20.10	26.50	20.00	153.40
	Total	28.60	21.70	21.30	21.40	21.20	27.80	35.00	177.00

Decision WHA73(30)	Human resources for health
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this decision would contribute:	1.1.5. Countries enabled to strengthen their health workforce
2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Not applicable.
4. Estimated time frame (in years or months) to implement the decision:	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\$ 29.12 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 6.55 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Not applicable.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	US\$ 11.14 million.

4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:
US\$ 11.43 million.
5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions
– Resources available to fund the decision in the current biennium:
US\$ 2.00 million.
– Remaining financing gap in the current biennium:
US\$ 4.55 million.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:
US\$ 4.55 million.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	0.50	0.25	0.25	0.50	0.25	0.25	1.00	3.00
	Activities	0.60	0.45	0.25	0.65	0.30	0.40	0.90	3.55
	Total	1.10	0.70	0.50	1.15	0.55	0.65	1.90	6.55
2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	1.04	0.52	0.52	1.04	0.52	0.52	2.08	6.24
	Activities	1.00	0.65	0.20	1.05	0.45	0.55	1.00	4.90
	Total	2.04	1.17	0.72	2.09	0.97	1.07	3.08	11.14
Future bienniums 2024–2025 resources to be planned	Staff	1.08	0.54	0.54	1.08	0.54	0.54	2.16	6.49
	Activities	0.88	0.68	0.21	1.09	0.47	0.57	1.04	4.94
	Total	1.97	1.22	0.75	2.17	1.01	1.11	3.20	11.43

Decision WHA73(32)	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan
A. Link to the approved Programme budget 2020–2021	
1. Outputs in the approved Programme budget 2020–2021 to which this decision would contribute:	2.3.3. Essential health services and systems maintained and strengthened in fragile, conflict and vulnerable settings 4.2.1. Leadership, governance and external relations enhanced to implement GPW 13 and drive impact in an aligned manner at the country level, on the basis of strategic communications and in accordance with the Sustainable Development Goals in the context of United Nations reform 4.2.4. Planning, allocation of resources, monitoring and reporting based on country priorities, carried out to achieve country impact, value-for-money and the strategic priorities of GPW 13 4.3.4. Safe and secure environment with efficient infrastructure maintenance, cost-effective support services and responsive supply chain, including duty of care
2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.
3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021:	Not applicable.
4. Estimated time frame (in years or months) to implement the decision:	One year (November 2020–November 2021).
B. Resource implications for the Secretariat for implementation of the decision	
1. Total resource requirements to implement the decision, in US\$ millions:	US\$ 17.8 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions:	US\$ 17.8 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions:	Not applicable.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions:	Not applicable.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:	Not applicable.

5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions
– Resources available to fund the decision in the current biennium: US\$ 17.8 million.
– Remaining financing gap in the current biennium: Not applicable.
– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium: Not applicable.

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

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	–	–	–	–	3.8	–	–	3.8
	Activities	–	–	–	–	14.0	–	–	14.0
	Total	–	–	–	–	17.8	–	–	17.8
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
Future bienniums resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–

Decision WHA73(33)	Road map for neglected tropical diseases 2021–2030
A. Link to the approved Programme budget 2020–2021	
1. Output(s) in the approved Programme budget 2020–2021 to which this decision would contribute:	1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages 1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results 1.3.2. Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems 2.2.3. Mitigate the risk of the emergence and re-emergence of high-threat pathogens
2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2020–2021:	Not applicable.

3. Any additional Secretariat work during the biennium 2020–2021 that cannot be covered by the approved Programme budget 2020–2021: None at present. The starting phase of the implementation of the new neglected tropical diseases road map will require some scaling up of activities following its publication as well as the release and dissemination of its complementary documents. As requested in the decision, this accelerated work also relates to advocating and providing technical assistance to Member States and partners. This can be carried out within the scope of the approved Programme budget 2020–2021 as planned.
4. Estimated time frame (in years or months) to implement the decision: 10 years.
B. Resource implications for the Secretariat for implementation of the decision
1. Total resource requirements to implement the decision, in US\$ millions: US\$ 544.9 million.
2.a. Estimated resource requirements already planned for in the approved Programme budget 2020–2021, in US\$ millions: US\$ 86.1 million.
2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2020–2021, in US\$ millions: Zero.
3. Estimated resource requirements to be considered for the proposed programme budget for 2022–2023, in US\$ millions: US\$ 107.8 million.
4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions: US\$ 351.0 million.
5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions – Resources available to fund the decision in the current biennium: - US\$ 65.0 million. – Remaining financing gap in the current biennium: - US\$ 21.1 million. Activities related to neglected tropical diseases are usually funded through voluntary and specific contributions which are provided on an annual basis. – Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium: - Negotiations and discussions are continuing to fill the financing gap for the current biennium.

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

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2020–2021 resources already planned	Staff	9.0	1.5	1.5	0.3	1.0	0.8	24.5	38.6
	Activities	11.0	3.5	11.0	0.9	4.5	2.6	14.0	47.5
	Total	20.0	5.0	12.5	1.2	5.5	3.4	38.5	86.1
2020–2021 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2022–2023 resources to be planned	Staff	9.3	1.5	2.8	0.3	1.3	1.0	25.0	41.2
	Activities	13.0	3.5	25.0	1.3	4.9	3.0	16.0	66.7
	Total	22.3	5.0	27.8	1.6	6.2	4.0	41.0	107.8
Future bienniums resources to be planned	Staff	28.0	5.5	15.0	0.9	4.1	3.3	79.0	135.8
	Activities	45.0	15.5	75.0	4.3	16.0	9.5	50.0	215.3
	Total	73.0	21.0	90.0	5.2	20.1	12.8	129.0	351.0

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