World Health Organization

EXECUTIVE BOARD **EB135/PSR/1**
135th session **7 July 2014**

PROVISIONAL SUMMARY RECORD OF THE FIRST MEETING

WHO headquarters, Geneva
Monday, 26 May 2014, scheduled at 09:30

Chairman: Professor J. HALTON (Australia)
later: Dr M. SHAKEELA (Maldives)

CONTENTS

FIRST MEETING

Monday, 26 May 2014, at 09:40

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1. OPENING OF THE SESSION

The CHAIRMAN declared open the 135th session of the Executive Board and said that the Board would proceed to elect its Chairman, Vice-Chairmen and Rapporteur before adopting its agenda.

2. ELECTION OF CHAIRMAN, VICE-CHAIRMEN AND RAPPORTEUR: Item 1 of the Provisional agenda

The CHAIRMAN drew attention to Rule 12 of the Rules of Procedure of the Executive Board, which set out the procedures for electing the Officers of the Board. Following the principle of rotation among geographical WHO regions, Dr Mariyam Shakeela, Maldives had been nominated for the office of Chairman of the Executive Board. In the absence of other nominees, and pursuant to Rule 48 of the Rules of Procedure of the Executive Board, the Board could decide to proceed without taking a ballot on the agreed candidate.

Dr Mariyam Shakeela (Maldives) was elected Chairman.

Professor HALTON (Australia) congratulated Dr Shakeela on her election and said that it had been an honour to serve as Chairman of the Executive Board. In taking forward the process of WHO reform, she had come to realize the value of good humour, patience and courtesy, and she called on the Board to continue its work on behalf of the global population.

The DIRECTOR-GENERAL paid tribute to Professor Halton, who had served WHO in many capacities, including as Chairman of the Executive Board and of its Programme, Budget and Administration Committee, as President of the World Health Assembly, and as Chair of the Intergovernmental Meeting on Pandemic Influenza Preparedness: Sharing of Influenza Viruses and Access to Vaccines and other Benefits.

Dr Shakeela took the Chair.

The CHAIRMAN, having expressed appreciation to the outgoing Chairman, said that she was honoured to be elected Chairman of the Executive Board. She welcomed the new Board members and said that the outcome of the Board's future work would constitute a further important step in the history of the Organization.

She drew attention to Rule 12 of the Rules of Procedure of the Executive Board, which set out the procedures for electing the Officers of the Board. Following the principle of geographical rotation, and on the basis of consultations in the respective regions, the following nominations had been made for the four Vice-Chairmen: Dr Yankalbe Paboung Matchock Mahouri (Chad) (African Region),

Dr Jarbas Barbosa da Silva Júnior (Brazil) (Region of the Americas), Dr Walid Ammar (Lebanon) (Eastern Mediterranean Region) and Dr Dirk Cuypers (Belgium) (European Region).

Dr Yankalbe Paboung Matchock Mahouri (Chad), Dr Jarbas Barbosa da Silva Júnior (Brazil), Dr Walid Ammar (Lebanon) and Dr Dirk Cuypers (Belgium) were elected Vice-Chairmen.

The CHAIRMAN said that, under Rule 15 of the Rules of Procedure of the Executive Board, if the Chairman was unable to act in-between sessions, one of the Vice-Chairmen should act in his or her place; the order in which the Vice-Chairmen would be requested to serve should be determined by lot at the session at which the election had taken place.

It was determined by lot that the Vice-Chairmen would serve in the following order: Dr Cuypers (Belgium), Dr Ammar (Lebanon), Dr Matchock Mahouri (Chad) and Dr Barbosa da Silva Júnior (Brazil).

The CHAIRMAN said that, pursuant to Rule 12 of the Rules of Procedure of the Executive Board and in accordance with the principle of rotation among geographical regions, Mr Jeon Man-bok (Republic of Korea) had been nominated as Rapporteur.

Mr Jeon Man-bok was elected Rapporteur.

Dr VALVERDE (Panama) congratulated the Chairman on her election, expressed appreciation to the outgoing Chairman and welcomed the new Board members.

3. ORGANIZATION OF WORK

Mrs VUKOVIĆ (Croatia) said that, as agreed in the exchange of letters in 2000 between WHO and the European Commission on the consolidation and intensification of cooperation, and without prejudice to any future general agreement between WHO and the European Union, the European Union attended sessions of the Board as an observer. She requested that, at the 135th session of the Board, as at previous sessions, representatives of the European Union be invited to participate without vote in the meetings of the Board and its committees, subcommittees, drafting groups or other subdivisions that addressed matters falling within the European Union's competence.

The CHAIRMAN took it that the Board wished to accede to the request.

It was so agreed.

4. ADOPTION OF THE AGENDA: Item 2 of the Provisional agenda (Documents EB135/1 and EB135/1 (annotated)

The agenda was adopted.

5. OUTCOME OF THE SIXTY-SEVENTH WORLD HEALTH ASSEMBLY: Item 3 of the Agenda

Dame Sally DAVIES (United Kingdom of Great Britain and Northern Ireland) said that it had become clear at the Sixty-seventh World Health Assembly that the reform process had some way to go. Although it was the Member States that drove the Organization, they needed guidance in order for their participation to have the greatest impact. She therefore urged the Secretariat to increase its efforts in that regard, particularly in advising the chairmen of the main committees as they dealt with their lengthy agendas.

Dr GWENIGALE (Liberia) said that, in the context of the reform process, the Board should send a clear message to Member States discouraging delegates from reading out lengthy prepared statements describing their own national situation and urging them to confine their interventions to the agenda item under discussion. In that way, it should be possible to ensure that meetings finished on time.

Dr OMI (Japan), referring to an issue discussed at the recent session of the Health Assembly, said that, although the reports submitted two years before to the Health Assembly and the Board had presented a relatively optimistic report on the situation of poliomyelitis, the situation was now described as a public health emergency. The factors responsible for poliomyelitis were beyond the control of the health sector alone, and he therefore urged the Secretariat to redouble its efforts to reach out to non-health sectors and other United Nations agencies. Given that the declaration of a public health emergency covered only a three-month period, he proposed that the Secretariat should organize a second meeting of the International Health Regulations (2005) Emergency Committee to ensure that the international community remained vigilant.

Turning to the subject of the governing bodies' workload, he said that WHO faced a dilemma: the need to respect the right of Member States to propose new agenda items while simultaneously limiting the total number of items. It was difficult to oppose requests made by Member States in an open forum, such as the Board. He therefore proposed that, as suggested at the previous session of the Board, the Director-General and the Chairman of the Board should review all requests to include additional items and submit counter-proposals, with the Board taking the final decision. Some items might be better discussed in other forums, such as the regional committees. Member States should use meeting time at the Health Assembly for genuine discussion, while the information on a country's health situation which currently formed the major part of most statements could, for example, be posted on the WHO website.

Mrs VUKOVIĆ (Croatia) expressed her appreciation to the Regional Office for Europe and the WHO Croatia country office for their prompt assistance and valuable support during the current severe flooding in her own and neighbouring countries. The Board could be satisfied with the outcome of the Sixty-seventh World Health Assembly. Despite a very lengthy agenda and a session lasting only one week, many important resolutions and decisions had been adopted following exhaustive negotiations. Progress had also been made on WHO reform.

Dr REN Minghui (China) concurred with previous speakers. One solution might be to delegate responsibility to the General Committee for decisions on the resolutions to be discussed. Member States could not put pressure on the Secretariat to improve the efficiency of the Health Assembly while they continued to make lengthy statements about their national situations. Country reports should be uploaded to the WHO website instead. Although the progress reports were important, they did not receive as much attention as other agenda items, and he therefore proposed that they should be discussed on the first day of the Health Assembly, when more time could be allocated to them.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the documents submitted to Member States for discussion at the Health Assembly should be more analytical and should indicate the aspects that were to be discussed and approved by the Health Assembly, so that countries would not merely present a catalogue of their own national actions.

Dr KAMWI (Namibia) said that the key to the efficient management of meetings was a chairman who could exercise control and ensure that participants spoke only for the allotted time.

Ms ADAM (Maldives) said that the progress reports could be considered initially by the regional committees. A consolidated response from each regional committee could then be presented to the Health Assembly for further discussion.

Ms AXELROD (Russian Federation) said that the strict enforcement of the three-minute rule for speakers in recent sessions should be maintained. It would be appreciated if Secretariat documents were sent out more promptly so that Board members and Member States could prepare their positions.

Mr KLEIMAN (Brazil) recognized the difficulty of reconciling the perceived need to limit the number of agenda items with the right of Member States to report on their national situations. The setting of the agenda should be discussed as part of the WHO reform process.

Dr VALVERDE (Panama) said that both proposed agenda items and draft resolutions should be discussed in an inclusive and transparent manner well before the Health Assembly. The creation of numerous drafting groups made it hard for countries, particularly those with small delegations, to discuss the agenda properly.

Dr KUPA (Democratic Republic of the Congo) placed emphasis on the relevance to Member States of all the subjects that had been discussed during the Health Assembly. The work had been well organized and had focused on genuine priority areas. He encouraged the Board to make the most efficient use of its time during the current session in order to produce worthwhile outcomes.

Dame Sally DAVIES (United Kingdom of Great Britain and Northern Ireland) supported several constructive ideas put forward by previous speakers that were worthy of careful consideration: more use of digital technology, limiting the length of both documents and speaking time, more focused documents; reducing the number of agenda items; and above all, discipline, rigorously applied.

Mr CASALS ALIS (Andorra) suggested that the solutions proposed by Board members should be considered by the Chairman and the Director-General before they were formally discussed by the Board at its next session.

Dr ASADI-LARI (Islamic Republic of Iran) said that, while he appreciated the need to limit the workload of the Health Assembly, it was nevertheless the main platform for all Member States to discuss global health issues and raise national and local concerns that might have implications for health. Compromise and more work by the Secretariat were needed to balance those two concerns.

Professor HATEM (Egypt) welcomed the adoption by the Health Assembly of the draft resolution on hepatitis recommended by the Executive Board.

Dr AL-OBAIDI (Kuwait) congratulated the Chairman on her election. As a recently elected member of the Board, he hoped to add value to its deliberations.

Dr GWINJI (Zimbabwe)[1] welcomed the increasing use of communications technologies, including online consultations on matters of importance. However, where a common position or a decision was sought, the timing of such consultations required careful consideration. Taking as an example the discussions in the Health Assembly on the draft action plan for newborn health, he warned that to rely solely on online consultations might not be prudent. He therefore suggested holding physical meetings of Member States just before the Health Assembly, in order to avoid protracted debates during the session.

Ms ANDERSSON (Sweden),[1] while welcoming the important decisions taken by the Sixty-seventh World Health Assembly, said that the plethora of agenda items and resolutions, the creation of parallel drafting groups, insufficient time and a disregard for the established rules governing the conduct of Member States had undermined the overall efficiency of the session. Improvements in working methods were therefore needed in the areas of agenda items and resolutions, the conduct of business in committees, including adequate preparation of committee chairmen, and parallel drafting groups. She requested the Board to continue the discussion on governance reform at its 136th session, in January 2015.

Mr SAMAR (Algeria)[1] said that it was vital not to lose sight of the intergovernmental character of the Organization, the supremacy of the Health Assembly in decision-making and the need to guard the Organization against conflicts of interest. Its work for equity between countries, with attention focused on the most vulnerable population groups, would strengthen the right to health. In addition to ensuring a place for health issues in the post-2015 development agenda, it was also vital for WHO to promote international cooperation – North–South, South–South and triangular – aimed at providing support for national, regional and global plans for disease prevention and control.

Ms LANTERI (Monaco)[1] said that Member States had encountered unprecedented difficulties in getting through the agenda of the Sixty-seventh World Health Assembly. Delegations of small countries, including her own, had had to work non-stop around the clock, which was exhausting and unproductive. The proposals made by Board members at the current meeting should be compiled and circulated for discussion before the next session of the Board in January 2015, in order to avoid the situation being repeated in 2015.

Mr BOISNEL (France)[1] welcomed the concrete and constructive suggestions relating to governance which had been ably summarized by the member for the United Kingdom of Great Britain and Northern Ireland.

The DIRECTOR-GENERAL thanked members for their advice and comments. The Sixty-seventh World Health Assembly had been successful, but the long and intense meetings had placed a considerable strain on all concerned. Some changes were therefore needed. For example, although a drafting group had devoted eight meetings to discussing violence against women, girls and children, the Health Assembly had still reopened the subject. How could the Board fulfil its role of reducing the workload of the Health Assembly, if the latter insisted on reopening items that the former had already considered? In reply to the representative of Zimbabwe, she pointed out that the preliminary work he was advocating was already carried out during intersessional informal consultations. However, that did not prevent items that had been agreed upon being reopened at the Health Assembly.

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

With regard to suggestions for improving documents, such as making them more concise, providing better guidance or issuing them earlier, she emphasized that if the number of documents generated by the agenda exceeded the Secretariat's capacity, it would be impossible to make the necessary changes. Member States would need to assume some responsibility in that regard. In the comparative calm of the Board, it was easy to make rational comments; however, the good intentions professed appeared to vanish in the throes of WHO business. She recognized the right of every country to discuss matters they deemed important, but such discussions must be disciplined. Expressing her sympathy for small delegations, she said that the need to attend several drafting groups simultaneously undermined the principles of inclusiveness and solidarity.

The Chairman and she herself had put forward numerous proposals for reducing the number of agenda items but in the past their suggestions had been consistently rejected, and she doubted the situation had changed. With regard to improving the guidance provided for the officers of the Health Assembly, she said that the President of the Sixty-seventh World Health Assembly had received enormous support from his own Government, as well as from the Secretariat. Suggestions that regional committees might consider the progress reports and that more responsibility should be given to the General Committee would both be the subject of future reflection in the context of WHO reform, as would the alignment of priority agenda items between the global governing bodies and the six regional committees.

Acknowledging that a temporary recommendation under the International Health Regulations (2005) lasted for only three months, she reassured the member for Japan that a meeting of the Emergency Committee would be convened before the deadline to investigate the evolving situation of poliomyelitis, so there should be no gaps in the advice provided. She offered her sympathy to the people of Croatia and its neighbours on the devastation caused by the recent flooding, with the associated risk of disease outbreaks. She commended the support provided by the Regional Office for Europe and country offices.

All the proposals put forward by the Board members would be carefully reviewed and lessons would be learned from the Health Assembly. She urged health ministers to liaise with their counterparts in other ministries, as a whole-of-government approach had already been shown to enhance the quality of governing body discussions.

Working Group on Strategic Budget Space Allocation

The CHAIRMAN drew the Board's attention to the Director-General's proposal in paragraph 11 of document A67/9 that the current membership of the Working Group should be maintained, so that work on the issue could continue.

Dame Sally DAVIES (United Kingdom of Great Britain and Northern Ireland), while acknowledging the benefits of retaining the expertise acquired by the members of the Working Group over several years, noted that some members had now left the Executive Board and thus also the Programme, Budget and Administration Committee. It was unclear whether members of the Working Group had also to be members of the Board.

Mr BURCI (Legal Counsel) explained that the members of the Working Group had become very involved in the process and it had been felt that, exceptionally and in the interests of maintaining continuity, the current membership should be preserved. A clear link would be maintained with the Programme, Budget and Administration Committee to ensure that the overall process continued to be owned by the Committee and the Board.

The CHAIRMAN said that, in the absence of any objection, she took it that the Board agreed to maintain the current membership of the Working Group, namely: Belgium, Cameroon, Egypt, Malaysia, Maldives and Mexico.

It was so decided.[1]

6. REPORT OF THE PROGRAMME, BUDGET AND ADMINISTRATION COMMITTEE OF THE EXECUTIVE BOARD: Item 4 of the Agenda (Document EB135/2)

Dr CUYPERS (Belgium), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, drew attention to the report of the Committee's twentieth meeting (document EB135/2). He summarized the Committee's deliberations on the items covered in the report that were not on the Board's agenda, namely, the annual report of the Independent Expert Oversight Advisory Committee and progress on implementation of external and internal audit recommendations.

Ms ADAM (Maldives) asked for the Working Group on Strategic Budget Space Allocation to be informed at its next meeting of the reasons for limiting country-level technical assistance to 23% for all Member States, which amounted to less than US$ 1 billion out of a global budget of US$ 4 billion and compared with country-level allocations of between 55% and 60% in 2006. In order to throw more light on budget allocation for the next biennium, she requested the Secretariat to indicate the proportion of funds to be allocated to Member States in the current biennium. She proposed that, in future, the weighting given to criteria, as well as that between the four operational segments, should be transparent, in particular with regard to segment 1.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) commended the work of the Programme, Budget and Administration Committee and welcomed the valuable and rich report of the Independent Expert Oversight Advisory Committee. She hoped to see a prompt and serious response to it through action by WHO.

The DIRECTOR-GENERAL, responding to the point raised by the member for Maldives, said that when analysing the four operational segments it was important to understand that considerably more than the 23% specified for one segment was used for supporting countries. A significant proportion of segment 2, which related to the regional offices and headquarters, also went to countries, for example through visits by experts from those offices when countries experienced particular disease outbreaks. Overall, she estimated that a sum closer to 50% of WHO's resources was used for supporting countries but agreed with the need for further horizontal and vertical analyses of the segments in order to show explicitly the proportion of each that went to countries.

The Board noted the report.

[1] Decision EB135(1).

7. TECHNICAL AND HEALTH MATTERS: Item 5 of the Agenda

Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage: Item 5.1 of the Agenda (Document EB135/3)

Mr KOLKER (United States of America) said that task-shifting and more rational use of resources would help to improve access to surgical procedures within primary health care, which could save lives, particularly in low- and middle-income countries where the need for surgical care was greatest. He asked for an item on emergency and essential surgical care and anaesthesia to be included on the agenda of the 136th session of the Board, pending the preparation of a draft resolution on the subject.

Dr AL-OBAIDI (Kuwait) said that more needed to be done to reduce the disparities in access to emergency and essential surgical care, both between and within countries. WHO should provide technical guidance on establishing and strengthening such services within primary and secondary health care.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the report should place more emphasis on the need for close links between the various levels of care so that, for example, a patient with major head trauma presenting at a primary health care facility could be quickly transferred to a higher-level facility for treatment. It should also pay more attention to anaesthetic services since, worldwide, a patient was more likely to have a surgeon available than an anaesthetist.

Dr REN Minghui (China) agreed that the issue of emergency and essential surgical care and anaesthesia should be included on the agenda of the Board at its next session. However, other related services, such as medical imaging and medical technology, must also be considered, and appropriate components of the service and indicators to measure their performance must be identified.

Dr PILLAY (South Africa) said that the issue should be discussed by the Health Assembly at its next session.

Dr GWENIGALE (Liberia) said that many of the patients requiring emergency surgical care were young adults, with families who would be left destitute if the patient died. Anaesthetists were often involved in the resuscitation of newborn infants; that issue should also be reflected in any further discussions.

Dr KAMEYAMA (Japan) said that emergency surgical care and anaesthesia should be integrated into existing medical systems. Pre-hospital medical care should be provided at the community level to reduce the number of preventable deaths.

Dame Sally DAVIES (United Kingdom of Great Britain and Northern Ireland) said that any report submitted to the Board at its next session should also consider the need for access to and rational use of antibiotics in the context of emergency surgical care.

Ms ALGOE (Suriname) said that access to emergency and essential surgical care and anaesthesia should be assessed, by region, in all Member States so that gaps in those services could be properly mapped.

Dr KUPA (Democratic Republic of the Congo) said that a detailed baseline survey of technical and other needs at primary, secondary and tertiary care level would be required in order to avoid unwelcome surprises later.

Ms AXELROD (Russian Federation) said that the work already done on emergency surgery should be supplemented by a clearer definition of the content of emergency surgery programmes and by advocacy work to raise awareness about the issue. It was also important to address the provision of surgical care in rural and remote areas.

Dr KAMWI (Namibia) emphasized the need for well trained surgical health professionals and for adequate infrastructure and equipment, particularly at the district level, in order to guarantee equity and accessibility of care.

Dr NOOR HISHAM ABDULLAH (Malaysia) said that some countries were obliged to make a clear distinction between the services they could provide at primary level and at secondary level. Detailed definitions of emergency and essential surgical care and anaesthesia would be needed before they could comment on the appropriateness of integrating such services into primary health care. In his own country, the staff of specialist hospitals shared their expertise and resources and trained staff from non-specialist hospitals.

Professor HALTON (Australia) said that any future debate on emergency and essential surgery and anaesthesia should cover both antimicrobial resistance and the safety and quality of surgical care. It was important to determine the basic services and care that people should be able to access and receive through universal health coverage. However, in large countries, the reality was that the provision of even basic surgery was not feasible in every location; it was important not to create unrealistic expectations among the public. Her country would sponsor any future draft resolution.

Mr JEON Man-bok (Republic of Korea) said that the State should pay for emergency and essential surgical care, even in countries with social or private health insurance systems. WHO should provide further opportunities for Member States to share knowledge and experiences of strengthening such care.

Dr MISHRA (Nepal) said that the provision of anaesthesia services at the first-referral level was constrained both by a shortage of trained human resources and by problems of staff retention. Medical school curricula should include at least a basic level – to be defined with technical support from WHO – of training in anaesthesia.

Ms ADAM (Maldives) echoed the concerns expressed by the member for Cuba and called on Member States to coordinate their efforts to strengthen emergency and essential surgical care.

Dr AMMAR (Lebanon) said that a specific resolution was needed on the integration of surgical care into the health care delivery system, in the framework of the future WHO global strategy on people-centred and integrated health services. Task-shifting and the delivery of surgical care in primary care settings could provide an acceptable solution, if hospital care was not available. However, interventions must be limited to simple surgical procedures carried out by trained personnel in properly equipped health centres.

Mr KLEIMAN (Brazil), noting that his country was to host the 31st international conference of the International Society for Quality in Health Care in October 2014, said that it was important to

define priority actions on quality and patient safety, as well as indicators for monitoring national programmes.

Dr BEJTJA (Albania) said that the necessary skills for emergency surgical care must be built up and maintained, especially within smaller health care institutions. A balance must be struck between access to surgical services and the quality of those services, and the possibility of referral to a higher level or another part of the health care system must be preserved.

Mr GHEBRETINSAE (Eritrea) said that WHO should provide technical support and guidance to help countries develop strategies for the management of emergency and essential surgical care and anaesthesia at all levels of health care.

Mr SEY (Gambia) said that the issue should be discussed by the Board at its next session and included on the agenda of the next Health Assembly.

Mr CORRALES HIDALGO (Panama) said that national health planning should pay attention to inefficiencies within surgical services and emergency care, including the cost–effectiveness of surgery.

Mr CASALS ALIS (Andorra) said that there should be more cross-border health cooperation. Andorra, a small country, had established agreements with its neighbours, France and Spain, to ensure the necessary access to health services.

Mr PIPPO (Argentina) said that emergency surgical care and anaesthesia services should be strengthened, inter alia, by enhancing coordination between primary health care services and hospitals. Human resource capacity should also be increased by means of ongoing training, and the issue of migration of health professionals should be addressed.

Dr MATCHOCK MAHOURI (Chad) said that his country had already achieved the political commitment to surgical services advocated in the report, with monthly meetings chaired by the Head of State. He stressed the importance of conducting a baseline assessment of the health situation before introducing new services.

Dr ASADI-LARI (Islamic Republic of Iran) called on the Secretariat to prepare a technical report on all aspects of essential surgical care and anaesthesia, to be considered by the Board at its 136th session.

Mrs SINJELA (Zambia)[1] hoped that any resolution that was adopted would help countries to assess their health systems and identify gaps in surgical and anaesthetic service delivery; incorporate an essential package of surgical and anaesthetic services into national health strategies and budgets; improve surgical training for existing and new front-line health workers; improve surgical and anaesthesia infrastructure; and monitor and evaluate the provision of services.

Dr SUTHAT DUANGDEEDEN (Thailand)[1] said that there were gaps in countries' capacity to provide timely and effective surgical care, in particular at primary health care level in disaster-prone areas. The term "essential surgical care" must be precisely defined.

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

Mr ALI YAHIA ELABASSI (Sudan)[1] said that efforts to strengthen emergency and essential surgical services and anaesthesia should focus on low-income countries and include training for health professionals and an efficient mechanism for monitoring the outcome of activities.

Dr ELOAKLEY (Libya)[1] expressed support for the proposal to include the subject item on the agenda of the Sixty-eighth World Health Assembly and to prepare a draft resolution for submission to the Executive Board at its 136th session. The discussion should cover the issue of antimicrobial resistance and explore a wider range of methods for funding health care services. It was important to emphasize that health care expenditure should be the responsibility of both governments and individuals.

Dr WILKINSON (World Federation of Societies of Anaesthesiologists), speaking at the invitation of the CHAIRMAN, called on Board members to give their full support to efforts to strengthen emergency and essential surgical care and anaesthesia. An indicator such as perioperative mortality would be required to measure progress.

Professor GUNN (International Federation of Surgical Colleges), speaking at the invitation of the CHAIRMAN, said that extending essential surgical care to developing countries was an urgent priority and one that was not only financially bearable and cost–effective but also a moral obligation.

Professor SPIEGEL (International Society of Orthopaedic Surgery and Traumatology), speaking at the invitation of the CHAIRMAN, said that the incidence of musculoskeletal conditions and the global burden of trauma and injuries were enormous and increasing. That burden could be significantly reduced, however, by closing the gaps in access to safe and timely surgical services. He further called on Member States to take the action required to protect health care personnel from threats, aggression and physical violence, which compromised the health care system.

Ms WANJAU (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that surgical care had previously been neglected in global health discourse, largely because of misconceptions over its cost. She called on the Secretariat and Member States to expand the scope of surgery in public health discussions beyond emergency interventions so that it included comprehensive, quality surgical care; to consider surgery as a key component of health system strengthening; to address the current global disparity in and inequity of access to surgical care; and to ensure that appropriate numbers of surgeons were trained.

Ms THOMAS (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that several surgical procedures could be performed by staff with more limited training than those employed in large hospitals, although training programmes must be carefully designed. Some types of surgery could be referred to a higher-level facility or performed by a visiting surgical team. Ensuring that surgical services were effective required systems for gathering evidence and data, generating guidelines and encouraging compliance. She called upon WHO to include surgeons with experience of performing surgery in low-resource settings in any expert committees that it set up.

Dr KIENY (Assistant Director-General) welcomed the wide-ranging support for the inclusion of the topic on the agenda of the Sixty-eighth World Health Assembly, following consideration by the Executive Board. The Secretariat had taken note of the various points made during the discussion,

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

including the conviction that surgical care and anaesthesia should be considered a core aspect of universal health coverage; the need for safe, effective and affordable antibiotics to avoid infection resulting from surgery and the related issue of addressing antimicrobial resistance; the need to strengthen human resource capacities; and the need to carry out a thorough baseline assessment of the current situation so as to better understand what measures needed to be taken. Those points would all be reflected in a new version of the report by the Secretariat, which would be sent to Member States in preparation for discussions by the Executive Board at its 136th session.

The DIRECTOR-GENERAL said that the number of Member States that had spoken on the subject testified to the importance that they ascribed to it. In the context of overall health system strengthening, Member States had underscored the importance of access, safety and quality. Relevant professional associations and organizations could help to demystify some of the measures that might be necessary: she agreed, for example, that there was not always a need for fully trained specialists in anaesthesia or surgery to work in primary health care. Task-shifting was an important concept to consider. The most important thing was that health care workers needed to have adequate training, to be properly supervised and to provide safe and high-quality care to patients.

WHO would facilitate discussions between Member States as they sought to transfer and share experience and knowledge and defined the types of solutions that they wanted. She was disappointed, however, that nobody had mentioned the importance of prevention, which could alleviate some of the pressure on Member States in terms of the growing need and cost of surgical interventions.

The CHAIRMAN took it that, in the absence of any objections, the Executive Board wished to include strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage on the provisional agenda of its 136th session.

It was so agreed.

The meeting rose at 12:35.

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