EXECUTIVE BOARD
138th session

EB138/PSR/10
18 March 2016

PROVISIONAL SUMMARY RECORD OF THE TENTH MEETING

WHO headquarters, Geneva
Thursday, 28 January 2016, scheduled at 18:00

Chairman: Ms M.P. MATSOSO (South Africa)
later: Dr J.M. CASALS ALÍS (Andorra)

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TENTH MEETING

Thursday, 28 January 2016, at 18:05

Chairman: Ms M.P. MATSOSO (South Africa)
later: Dr J.M. CASALS ALÍS (Andorra)

1. COMMUNICABLE DISEASES: Item 9 of the Agenda (continued)

Global vaccine action plan: Item 9.3 of the Agenda (Document EB138/32) (continued)

The representative of BANGLADESH[1] said that Bangladesh had met most of the global targets for routine immunization and vaccine-preventable disease control under the global vaccine action plan and had completed the requirements for the establishment of a national regulatory authority. Prequalification by WHO was now needed, in order to make the authority operational.

The representative of INDIA[1] said that, although there had been some success stories, performance against key immunization targets under the action plan remained off track. Drawing attention to the requests to the Director-General in resolution WHA68.6 (2015) on the global vaccine action plan, he said that the Director-General's report on the implementation of WHA68.6 should be incorporated into the Secretariat's report to the Sixty-ninth World Health Assembly.

The representative of INDONESIA[1] said that the action plan was in line with her country's national development plan, which provided for monitoring, evaluation and accountability in the implementation of its immunization programme. She encouraged WHO to facilitate transfers of vaccine technology between manufacturing countries, so as to forestall a global shortage of inactivated polio vaccine in 2016. WHO should also put in place a mechanism for pooling vaccine procurement. All stakeholders involved in promoting child health should mobilize resources with a view to enabling all children to have access to quality immunization services.

The representative of MEDICUS MUNDI INTERNATIONAL (International Organization for Cooperation in Health Care),[1] speaking at the invitation of the CHAIRMAN, considered that the report by the Secretariat failed to address several issues identified in resolution WHA68.6 and urged members to ask for a comprehensive and systematic report on the resolution's implementation. Data on the introduction of new vaccines could not be the sole or even principal measure of the action plan's success. New vaccines should be introduced on the basis of disease burden, public health capacity, local manufacturing capacity and affordability. All Member States should provide pricing data, and demand reporting on the technical, procedural and legal barriers that could undermine competition and on the improved coordination and funding of the research and development required to introduce new vaccines at affordable prices. Lastly, WHO could provide valuable data and technical assistance to support both local manufacturing and pooled procurement, which were key for the 24 middle-income countries that had graduated from GAVI Alliance support.

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

The representative of MSF INTERNATIONAL, speaking at the invitation of the CHAIRMAN, welcomed the recommendations of the Strategic Advisory Group of Experts on immunization, and urged the Secretariat to report on the operative sections of resolution WHA68.6 in its next report on the action plan. Lack of competition kept vaccine prices high. That was particularly true for the newest vaccines, which might have only two WHO prequalified manufacturers each. WHO should use its technical and regulatory expertise to support developing country vaccine regulators with a view to timely licencing and prequalification, especially of pneumococcal vaccine candidates. It should also prioritize implementation of its existing guidelines, thereby enabling humanitarian organizations like MSF International to access vaccines at the lowest global price and immunize crisis-affected children.

The ASSISTANT DIRECTOR-GENERAL (Family, Women's and Children's Health) expressed her appreciation to the Strategic Advisory Group of Experts for its report on the status of the action plan's implementation. The elimination of neonatal and maternal tetanus in India and of rubella and congenital rubella in the Americas, and the absence of any cases of wild polio virus in Africa since August 2014, were particularly laudable developments. The action plan's goals nevertheless remained elusive, and the Secretariat had taken a number of steps in 2015 to achieve them and to implement the recommendations made by the Strategic Advisory Group of Experts in its 2014 assessment report. All WHO regions had finalized their immunization plans. In February 2016, the African and the Eastern Mediterranean regions, working in conjunction with the African Union, would host the Ministerial Conference on Immunization in Africa, in order to boost the political leadership and commitment required for progress. Forty countries had revised their multiyear plans. The Secretariat was intensifying its action in cooperation with the GAVI Alliance and partners, and urged Member States to share information on vaccine prices. It was working to facilitate access by middle-income countries to vaccines, and was finalizing the framework for immunization in humanitarian crises. The production in record time of a vaccine against Ebola virus disease demonstrated the benefits of partnership and showed that rapid progress could be made in crisis situations.

The Board noted the report.

Dr J. M. Casals Alís took the Chair.

Mycetoma: Item 9.4 of the Agenda (Document EB138/33)

The CHAIRMAN drew attention to the report on mycetoma, the associated draft resolution and its financial implications. The draft resolution, proposed by Egypt, Nigeria and Sudan, read:

> The Executive Board,
> Having considered the report on mycetoma,[1]
>
> RECOMMENDS to the Sixty-ninth World Health Assembly the adoption of the following resolution:
>
> > The Sixty-ninth World Health Assembly,
> > (PP1) Deeply concerned about the impact of mycetoma, especially among children and young adults of working age, and the public health and socioeconomic burdens that the disease places on poor, rural communities;

[1] Document EB138/33.

(PP2) Aware that early detection and treatment minimize the adverse consequences of mycetoma;

(PP3) Noting with satisfaction the progress made by some Member States with regard to research into mycetoma and management of cases of the disease;

(PP4) Concerned that several factors, including late detection of cases of mycetoma and inadequacy of available tools for diagnosis, treatment and prevention of the disease, impede further progress;

(PP5) Mindful that achievement of the United Nations Millennium Development Goals and the Goals of the 2030 Agenda for Sustainable Development, particularly those concerning poverty, hunger, health and education, may be hampered by the negative impact of neglected diseases of the poor, including mycetoma,

(OP) 1. CALLS UPON the international community and all stakeholders including, inter alia, the international organizations, bodies of the United Nations system, donors, nongovernmental organizations, foundations and research institutions:

(1) to cooperate directly with countries in which the disease is endemic, upon the request of such countries, in order to strengthen control activities;

(2) to develop partnerships and foster collaboration with organizations and programmes involved in health system development in order to ensure that effective interventions can reach all those in need;

(3) to support institutions working on research on mycetoma;

(OP) 2. ENCOURAGES Member States in which mycetoma is, or threatens to become, endemic:

(1) to assess the burden of mycetoma and, where necessary, establish a control programme;

(2) to accelerate efforts for early detection and treatment of mycetoma cases;

(3) to integrate, where feasible, efforts to control mycetoma with other relevant disease-control activities;

(4) within the context of health-system development, to establish and sustain partnerships for control of mycetoma at country and regional levels;

(5) to meet control needs, including in respect of improved access to treatment and rehabilitation services, by mobilizing national resources;

(6) to provide training to relevant health workers on the management of mycetoma;

(7) to intensify research in order to develop new tools to diagnose, treat and prevent mycetoma;

(8) to promote community awareness of disease symptoms in support of early detection and prevention, and to intensify community participation in control efforts;

(OP) 3. REQUESTS the Director-General:

(1) to include mycetoma among the diseases termed “neglected tropical diseases”;

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

(3) to support Member States in which the disease is endemic to strengthen capacities for improving early detection and access to treatment;

(4) to foster technical cooperation among countries as a means of strengthening surveillance, control and rehabilitation services;

(5) through the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, to support the strengthening of research capacity in order to meet the need for better diagnostics, treatments and preventive tools for mycetoma;
(6) to report on progress in implementing this resolution, through the Executive Board, to the Seventy-second World Health Assembly.

The financial and administrative implications of the draft resolution for the Secretariat were as follows:

Resolution: Addressing the burden of mycetoma

A. Link to the general programme of work and the programme budget

1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.

Twelfth General Programme of Work, 2014–2019: Outcome 1.4 Increased and sustained access to essential medicines for neglected tropical diseases.

Programme budget 2016–2017: Output 1.4.2 Implementation and monitoring of neglected tropical disease control interventions facilitated by evidence-based technical guidelines and technical support; and Output 1.4.3 New knowledge, solutions and implementation strategies that respond to the health needs of disease-endemic countries.

The activities mandated by the resolution are part of the deliverables that need reinforcement specifically for the control of mycetoma. The UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases no longer engages in managing research and development for drugs and diagnostics, should such be required for mycetoma, but would assist the Secretariat in convening expert groups to analyse the situation and form research priorities. The funds required to take these priorities forward are not included in the present report.

2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.

Not applicable.

3. What is the proposed timeline for implementation of this resolution?

10 years.

If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.

B. Budgetary implications of implementation of the resolution

1. Current biennium: estimated budgetary requirements, in US$

Level	Staff	Activities	Total
Country offices	300 000	300 000	600 000
Regional offices	200 000	200 000	400 000
Headquarters	400 000	100 000	500 000
Total	900 000	600 000	1 500 000

1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)

Yes.

1(b) Financing implications for the budget in the current biennium:

– How much is financed in the current biennium?

None.

– What are the gaps?

US$ 1 500 000

– What action is proposed to close these gaps?

Advocacy, reprioritizing, resource mobilization. A potential source of external funding may be negotiated with WHO partners through product development partnerships.

2. Next biennium: estimated budgetary requirements, in US$

Level	Staff	Activities	Total
Country offices	400 000	400 000	800 000
Regional offices	300 000	250 000	550 000
Headquarters	500 000	150 000	650 000
Total	1 200 000	800 000	2 000 000

2(a) Financing implications for the budget in the next biennium:

– How much is currently financed in the next biennium?

None.

– What are the financing gaps?

US$ 2 000 000

– What action is proposed to close these gaps?

Advocacy, reprioritizing, resource mobilization. A potential source of external funding may be negotiated with WHO partners through product development partnerships.

The representative of the UNITED STATES OF AMERICA welcomed the inclusion of mycetoma on the Board's agenda following several years of discussion. While sympathetic to the efforts to include the disease in the list of neglected tropical diseases, he was wary of setting a precedent by adding a disease on the basis of political, rather than technical, considerations. Following constructive consultations with the delegation of Sudan and others, he wished to propose a way forward that would lead to the same outcome but at the same time protect the integrity of WHO's norm and standard-setting role. First, his delegation would be prepared to retain the request to include mycetoma in the list of neglected tropical diseases if it was made clear that the Executive Board "noted" rather than "endorsed" the draft resolution. Second, in his summary of the discussion, the Chairman should note that the Strategic and Technical Advisory Group for Neglected Tropical Diseases had been requested to formulate, at its meeting in April 2016, a recommendation on the inclusion of mycetoma in the list of neglected tropical diseases, if possible, in time for its consideration at the Sixty-ninth World Health Assembly. Third, in order to clarify the process in the future, a new subparagraph should be added before subparagraph 3(6) of the draft resolution that would read: "through the Strategic and Technical Advisory Group for Neglected Tropical Diseases, to define a systematic, technically-driven process for evaluation and potential inclusion of additional diseases among the "neglected tropical diseases."

The representative of the REPUBLIC OF KOREA advocated the establishment of a mycetoma global surveillance system, aligned to target 3.3 of the Sustainable Development Goals. She requested WHO to play a leading role in developing strategies against the disease and supported the draft resolution. She expressed solidarity for all countries affected by mycetoma.

The representative of GAMBIA, speaking on behalf of the Member States of the African Region, acknowledged that mycetoma was a burden on his Region, although it was not a notifiable disease under the integrated disease surveillance system implemented by countries of the African Region. In Africa, most mycetoma cases were diagnosed at the later stages and were rarely treated with antibiotics or antifungal medicines. Surgical amputations were the most affordable treatment for patients, as that avoided further complications. Mycetoma was currently subject to increased surveillance, thanks to case findings for neglected tropical skin diseases such as leprosy, Buruli ulcers and yaws. Public health strategies for the control and prevention of mycetoma hinged on significant investment in research and product development, with the aim of promoting cost-effective prevention, diagnosis, early treatment and case management in low-resource settings. Given the current momentum towards the prevention, control and elimination of neglected tropical diseases, it was an opportune moment to raise funds to support research. He called on WHO to add mycetoma to the list of neglected tropical diseases so that it could receive the attention it deserved, both in terms of public health policy and control programmes in affected countries.

The representative of NAMIBIA, noting that it was high time to include mycetoma among the diseases termed neglected tropical diseases, suggested that in order to take into account the concerns that had been raised, the Executive Board could take a decision of principle on the issue at the current session and then efforts could be made to resolve all the technical concerns prior to the Sixty-ninth World Health Assembly in May 2016.

The representative of CANADA, endorsing the draft resolution, said that a broader health systems approach was critical to combating neglected tropical diseases and other poverty-related infectious diseases. Robust health systems able to deliver high-quality health services at a community level were not only key to improving the health of women, adolescents and children, but also to the prevention and management of all such diseases. She noted the need for more research to develop effective mycetoma treatments and field-friendly diagnostic techniques. Adequate preventive and control measures to reduce disease morbidity and mortality were needed.

The representative of EGYPT, speaking on behalf of Member States of the Eastern Mediterranean Region, said that mycetoma had received insufficient attention in his Region and that the treatment had doubtful efficacy, side-effects and toxicity. The omission of mycetoma from the list of neglected tropical diseases had certainly had an adverse effect on global attention to it. He endorsed the draft resolution and called for the inclusion of mycetoma on the list. WHO should sustain and document national-level campaigns against mycetoma; increase the powers of the WHO Collaborating Centre on Mycetoma in Khartoum to make it a global reference centre for knowledge about mycetoma; boost awareness through the Special Programme for Research and Training in Tropical Diseases; increase collaboration in respect of drug development; and coordinate the response to mycetoma in all public health strategies.

The representative of ERITREA, recalling that his country was situated within the so-called mycetoma belt, said that affected countries were ill-prepared and poorly equipped to provide the preventive, diagnostic, treatment and rehabilitation services required to combat mycetoma. His country wished to sponsor the draft resolution.

The representative of SWEDEN welcomed the establishment of the WHO Collaborating Centre on Mycetoma in Khartoum. She asked what measures were currently being taken by regional offices against mycetoma at the regional and country levels, particularly for prevention and early diagnosis. She supported the proposals by the United States of America, noting that they did not entail procedural delays.

The representative of SAUDI ARABIA, noting the spread of the disease among the poorest inhabitants of the many countries located in the mycetoma belt, said that a resolution on the subject would go a long way towards surmounting the challenges posed by the disease, and provide an incentive for national health systems, partners and stakeholders to produce strategies for overcoming it. His delegation therefore endorsed the draft resolution and called on others to follow suit.

The representative of KUWAIT expressed surprise at the proposal to refer the matter – which had been discussed by the Executive Board in January 2015 and by the World Health Assembly in May 2015 – to the Strategic and Technical Advisory Group for Neglected Tropical Diseases. She called on members to support the draft resolution in order to pave the way for its adoption at the forthcoming Health Assembly.

The representative of JORDAN said that mycetoma had caused countless problems in poor countries because of its late discovery and the lack of measures to curb it. He called on WHO to collect more information on the disease and expressed support for the draft resolution, including the proposal to include mycetoma in the list of neglected tropical diseases.

The representative of SUDAN, invited to take the floor by the CHAIRMAN at the request of the representative of THAILAND, recalled that, at the Sixty-eighth World Health Assembly, some Member States, including the United States of America, had expressed reservations concerning the legal procedures associated with adding mycetoma to the WHO list of neglected tropical diseases. Describing the steps that had been taken, he said that the process had been properly conducted and that there were precedents. Indeed, there was nothing to prevent a disease from being listed without referral to the Strategic and Technical Advisory Group for Neglected Tropical Diseases, which was not a governing body. Any further decision on the matter lay with the Executive Board.

The representative of THAILAND emphasized that social determinants of health and behavioural and anthropological factors were crucial to the prevention of mycetoma, mainly because medical and technological interventions were unreliable. Improvements to sanitation and health systems also played a significant role. She supported the draft resolution and the inclusion of mycetoma in the list of neglected tropical diseases.

The representative of CHINA, noting that there were isolated cases of mycetoma in her country, said that WHO should provide assistance to mycetoma-affected countries, boost research efforts, identify potential intervention areas and offer technical support so that countries could start surveillance and prevention programmes for neglected tropical diseases.

The representative of BRAZIL, expressing his support for the draft resolution, said that the Executive Board was the appropriate forum for seeking a compromise on the procedure going forward. The adoption of the draft resolution would attract global attention to neglected tropical diseases such as mycetoma, promote the development of new tools and ensure the integration of mycetoma campaigns into other neglected tropical disease programmes.

The representative of JAPAN said that, while he supported the draft resolution in theory, he shared the concerns of the United States of America and expressed interest in the suggestion by the representative of Namibia. The Strategic and Technical Advisory Group for Neglected Tropical Diseases could be asked to consider whether the inclusion of mycetoma on the list of neglected tropical diseases might undermine efforts to eradicate any other such diseases. Should the Advisory Group find that not to be the case, Japan would support the inclusion of mycetoma in the list of neglected tropical diseases.

The representative of INDIA[1] said that the Organization should support national and regional efforts to improve control of mycetoma. There was a need for better disease surveillance, the strengthening of health systems and further research and development into relevant diagnostics and medicines. As the disease met all the relevant WHO criteria, he advocated its inclusion in the list of neglected tropical diseases, which would raise the disease's profile, encourage greater collaboration among institutions and guarantee more technical support. His country wished to sponsor the draft decision.

The representative of the BOLIVARIAN REPUBLIC OF VENEZUELA[1] said that mycetoma should be added to the list of neglected tropic diseases, in part because it had not been appropriately dealt with in the past, owing to a lack of information on its prevalence, incidence and distribution. He supported the draft resolution.

The representative of the DRUGS FOR NEGLECTED DISEASES INITIATIVE, speaking at the invitation of the CHAIRMAN, said that her organization had recently included mycetoma in its portfolio and was developing a potential new treatment – the only one currently in the pipeline. Lack of international awareness of the disease had brought about a gap in knowledge which had significantly affected patient care and hindered prevention and control efforts. International efforts should focus on epidemiology, treatments and preventive measures. She called on the Board to support the draft resolution.

The ASSISTANT DIRECTOR-GENERAL (HIV/AIDS, Tuberculosis, Malaria and Neglected Tropical Diseases) said the fact that so many speakers had taken the floor illustrated that mycetoma was not an issue that affected a few isolated regions, but a global public health threat. There were currently no specific procedures in place governing additions to or deletions from the list of neglected tropical diseases; however, the Strategic and Technical Advisory Group for Neglected Tropical Diseases would be called on to establish such procedures, and would consider mycetoma, during its meeting in April 2016. The Secretariat stood ready to work with the representatives concerned to amend the draft resolution in a way that would be mutually acceptable.

The representative of the UNITED STATES OF AMERICA said that he would be in favour of including mycetoma on the list of neglected tropical diseases as a result of a technically sound process carried out in time for the Sixty-ninth World Health Assembly. To reach consensus on the issue, however, more time was needed.

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

The representative of EGPYT, supported by the representative of THAILAND, said that, if there were no procedures in place for controlling which items were included on the list of neglected tropical diseases, any procedural argument against the adoption of the draft resolution could be rejected. As there was overwhelming support for the draft resolution's immediate adoption, and as it would not be in violation of any procedures to do so, he urged the Board to adopt the draft resolution.

The representative of FRANCE requested clarification from the Secretariat as to how exactly diseases were added to the list of neglected tropical diseases and the criteria applied by the Strategic and Technical Advisory Group for Neglected Tropical Diseases.

The DIRECTOR-GENERAL took note of the concerns expressed by the representative of the United States of America but also observed that the majority of members supported the draft resolution. Noting that it was not usual practice to vote on draft resolutions, she asked the Board whether it wished to suspend the discussion of the item in order to allow for further consultations and for agreement to be reached among members on suitable wording for the draft resolution.

The representative of KUWAIT said that many delegations, including her own, had expressed clear views on the issue from the outset. The issue had been on the table since the previous year and no failures of procedure were associated with it.

The representative of NAMIBIA observed that the positions taken by the various speakers seemed clear-cut. He reiterated his appeal to the Board to take a decision of principle on the matter at the current session; issues of a technical nature could be resolved at a later date.

The representative of JORDAN said he was confounded as to why the adoption of a draft resolution should be held up on the grounds of failure to follow procedure, if indeed there was no procedure to be followed. He saw no reason to defer adoption. Any concerns should have been raised a year previously, when the matter had first been referred to the Board.

The representative of the DOMINICAN REPUBLIC said that in cases where there were procedures to be followed, WHO should comply with them. However, as long as no procedures were being violated, the adoption of the draft resolution should not be deferred. Moreover, there was little point in deferring a decision on a matter on which the overwhelming majority agreed.

The representative of SAUDI ARABIA agreed that it was unnecessary to defer consideration of the draft resolution.

The representative of SOUTH AFRICA also agreed that a decision should be taken during the current discussions. The issue had been under discussion for one year already and the initial sponsor of the draft resolution, Sudan, had consulted the Secretariat, which had found there to be no procedural matters of concern. Even if the process of adjusting the list of neglected tropical diseases needed to be reviewed, that should not prevent mycetoma from being added to the list.

The representative of GAMBIA recalled that people were dying from mycetoma and WHO therefore had a responsibility to act immediately and to use its expertise where it was needed.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND said that her country was very supportive of action on neglected tropical diseases, as it had shown in the London Declaration on Neglected Tropical Diseases. There were currently no specific procedures in place for adjusting the list of neglected tropical diseases and even if such procedures

were established in the future, they should not be applied retroactively. She could agree to proceed with the adoption of the draft resolution with the addition of the subparagraph proposed by the representative of the United States of America, although she would prefer to use the wording "reviewing those diseases termed as neglected tropical diseases" instead of "evaluation and potential inclusion of additional diseases among the neglected tropical diseases".

The DIRECTOR-GENERAL confirmed that, in April 2016, the Strategic and Technical Advisory Group for Neglected Tropical Diseases would consider the process and criteria for modifying the list of neglected tropical diseases and that the output document would be ready in time for the Sixty-ninth World Health Assembly, in May 2016. The decision as to how to proceed remained in the hands of the members; the Secretariat would act according to their instructions.

The representative of the UNITED STATES OF AMERICA reiterated that WHO should base its work on technical, rather than political considerations. The list of neglected tropical diseases was a prioritized list and therefore adding diseases on account of political motivations would not only set a bad precedent but also devalue the list as a reliable set of priorities. Nevertheless, the proposal by the representative of the United Kingdom of Great Britain and Northern Ireland was acceptable, provided that the Strategic and Technical Advisory Group for Neglected Tropical Diseases would be mandated to keep the list up to date and consider which diseases should be added or removed.

The representative of NAMIBIA reiterated that he saw no reason why the Advisory Group could not be asked to apply its criteria to mycetoma after the Board had endorsed the draft resolution and before May 2016. Withholding the Board's endorsement until after the Advisory Group had given its approval would imply that responsibility for such decisions lay with the Advisory Group rather than with the Board, which was not the case.

The representative of JAPAN reiterated his concern that adding new diseases to the list would dilute efforts against those that were already on the list. However, if sufficient reasons were given for the inclusion of a disease on the list, he would have no objection.

The representative of SUDAN, invited to take the floor by the CHAIRMAN at the request of the representative of THAILAND, said that the proper legal processes had been followed in the preparation of the draft resolution and at no stage had any mention had been made of the Strategic and Technical Advisory Group for Neglected Tropical Diseases. Fundamentally, the Secretariat had performed all of the tasks assigned to it by the Executive Board at its 137th session and had presented the relevant documentation over 15 days in advance of the current session. No issue had ever been raised, however, until the previous day, which was frankly astounding, especially when there were already precedents of other diseases with less impact being included on the list of neglected tropical diseases. He therefore appealed to the Board to adopt the draft resolution for submission to the forthcoming Health Assembly. Procedural rules were always desirable but they must be followed in the proper manner.

The representative of MALTA observed that there seemed to be consensus for the adoption of the draft resolution with the addition of the subparagraph as proposed by the representatives of the United States of America and the United Kingdom of Great Britain and Northern Ireland.

The representative of INDIA[1] pointed out that the Strategic and Technical Advisory Group for Neglected Tropical Diseases already had its own terms of reference, and that the inclusion of the new subparagraph served only to duplicate them.

The draft resolution, as amended, was adopted.

HEALTH SYSTEMS: Item 10 of the Agenda

Health workforce and services: Item 10.1 of the Agenda (Documents EB138/34 and EB138/35)

Draft global strategy on human resources for health: workforce 2030 (Document EB138/36)

Framework on integrated people-centred health services (Document EB138/37)

The CHAIRMAN drew attention to a draft resolution sponsored by Norway, South Africa, Switzerland, Thailand, United States of America, Zambia, Zimbabwe and European Union Member States, on the global strategy on human resources for health: workforce 2030, which read:

> The Executive Board,
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> Having considered the report on the draft global strategy on human resources for health: health workforce 2030,[2]
>
> RECOMMENDS to the Sixty-ninth World Health Assembly the adoption of the following resolution:
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> > The Sixty-ninth World Health Assembly,
> >
> > (**PP1)** Having considered the report by the Secretariat on the draft Global Strategy on Human Resources for Health: Workforce 2030;
> >
> > (**PP2)** Reaffirming the continuing importance of the application of the WHO Global Code of Practice on the International Recruitment of Health Personnel (hereafter "WHO Global Code");[3]
> >
> > **(PP3)** Recalling previous Health Assembly resolutions aimed at strengthening the health workforce;[4]
> >
> > **(PP4)** Recalling also the United Nations General Assembly resolutions in 2014 and 2015 that call on Member States, in cooperation, as appropriate, with relevant international organizations and relevant non-State actors, to develop effective preventive

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

[2] Document EB138/36.

[3] Adopted through resolution WHA63.16 WHO Global Code of Practice on the International Recruitment of Health Personnel (2010).

[4] Resolutions WHA64.6 (2011) on health workforce strengthening, WHA64.7 (2011) on strengthening nursing and midwifery, WHA66.23 (2013) on transforming health workforce education in support of universal health coverage, WHA67.24 (2014) on follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage WHA65.20 (2012) on WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies and WHA68.15 (2015) on strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage.

measures to enhance and promote the safety and protection of medical and health personnel, as well as respect for their respective professional codes of ethics;[1] and that underline the importance of adequate country capacity to respond to public health threats through strong and resilient health systems with the availability of motivated, well trained and appropriately equipped health workers;[2]

(PP5) Inspired by the ambition of the 2030 Agenda for Sustainable Development, including its strong multisectoral dimension and call to achieve universal health coverage;

(PP6) Guided by Sustainable Development Goal 3(c)'s call to "substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States";

(PP7) Recognizing that health workers are integral to building strong and resilient health systems that contribute to the achievement of the Sustainable Development Goals and targets related to nutrition, health, education, gender, employment, and the reduction of inequalities;[3]

(PP8) Recognizing further that the Sustainable Development Goal 3 and its targets will only be attained through substantive and strategic investments in the global health workforce, as well as a substantial shift in health workforce-related planning, education, deployment, retention, management, and remuneration;

(PP9) Recognizing that countries' own domestic health workforce is the primary responder in all countries, including those with fragile health systems, and is key for building resilient health systems;[4]

(PP10) Deeply concerned by the rising global health workforce deficit and the mismatch between the supply, demand, and population need for health workers, now and in the future, which is a major barrier in achieving universal health coverage as committed to in Sustainable Development Goal target 3.8;

(PP11) Taking note of the renewed focus on health system strengthening and the need to mobilize and effectively manage domestic, international and other forms of health financing in its support;[5]

(PP12) Encouraged by the emerging political consensus on the contribution of health workers to improved health outcomes, to economic growth, to implementation of the International Health Regulations and to global health security;

(PP13) Recognizing that investing in new health workforce employment opportunities may also add broader socioeconomic value to the economy and contribute to the implementation of the Sustainable Development Goals,

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[1] United Nations General Assembly resolution 69/132 (2014) on global health and foreign policy.

[2] United Nations General Assembly resolution 70/L.32 (2015) on global health and foreign policy.

[3] See Sustainable Development goals and targets, available at https://sustainabledevelopment.un.org/?menu=1300 (accessed 25 January 2016).

[4] Resolution WHA64.10 (2011) on strengthening national health emergency and disaster management capacities and resilience of health systems; and document A68/27 on global health emergency workforce.

[5] The initiative Roadmap: Healthy Systems – Healthy Lives; Resolutions WHA64.9 (2011) on sustainable health financing structures and universal health coverage, WHA62.12 (2009) on primary health care, including health system strengthening, WHA64.8 (2011) on strengthening national policy dialogue to build more robust health policies, strategies and plans and WHA62.13 (2009) on traditional medicine.

(OP) 1. ADOPTS the Global Strategy on Human Resources for Health: Workforce 2030 (hereafter "Global Strategy"),[1] including its vision of accelerating progress towards universal health coverage and the Sustainable Development Goals by ensuring universal access to health workers, its principles, its four strategic objectives and its milestones for 2020 and 2030;

(OP) 2. URGES all Member States,[2] as integral to health systems strengthening:

(1) to adapt the Global Strategy's four strategic objectives within national health, education, and employment strategies, and broader socioeconomic development contexts, in line with national priorities and specificities;

(2) to engage relevant sectors and ensure intersectoral mechanisms at the national and subnational levels as required for efficient investment in and effective implementation of health workforce policies;

(3) to implement policy options as proposed for Member States by the Global Strategy, supported by high-level commitment and adequate financing, including through the implementation of the WHO Global Code, in particular towards:

(a) strengthening respective capacities to optimize the existing health workforce to contribute to the achievement of universal health coverage;

(b) actively forecasting and addressing gaps between health workforce needs, demands, and supply, including through intersectoral collaboration;

(c) building the institutional capacity at the subnational and national levels for effective governance and leadership of human resources for health; as e.g. an essential component for building comprehensive national health systems providing a long term solution in managing emergency outbreaks in their initial phase;

(d) consolidating a core set of human resources for health data with annual reporting to the Global Health Observatory, as well as progressive implementation of National Health Workforce Accounts, to support national policy and planning; and the Global Strategy's monitoring and accountability framework. [This includes annual reporting on steps taken to develop effective preventive measures to enhance and promote the safety and protection of medical and health personnel;][3]

(OP) 3. INVITES international, regional, national and local partners and stakeholders from within and beyond the health sector to engage in, and support, the implementation of the Global Strategy and its milestones for 2020 and 2030, in alignment with national institutional mechanisms to coordinate an inter-sectoral health workforce agenda, specifically calling for:

(1) education institutions to adapt their institutional set-up and modalities of instruction, aligned with national accreditation systems and populations' health needs; to train health workers in sufficient quantity, quality, and with relevant skills, while also promoting gender equality in admissions and teaching; and to

[1] To be attached at Annex following adoption of the resolution by the Health Assembly.

[2] And, where applicable, regional economic integration organizations.

[3] Resolutions WHA64.10 (2011) on strengthening national health emergency and disaster management capacities and the resilience of health systems), WHA65.20 (2012) on WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies and United Nations General Assembly resolution 69/132 (2014) on global health and foreign policy.

maintain quality and enhance performance through continuing professional development programmes;

(2) professional councils, associations, and regulatory bodies to adopt regulations to optimize workforce competencies, and to support inter-professional collaboration for a skills mix responsive to population needs;

(3) the International Monetary Fund, the World Bank, regional development banks and other financing and lending institutions to adapt their macroeconomic policies and investment criteria in light of mounting evidence that investments towards health workforce planning, and training, development, recruitment, and retention of health workers are productive to economic and social development and achievement of the Sustainable Development Goals;

(4) development partners, including bilateral partners and multilateral aid mechanisms, to augment, coordinate, and align their investments in education, employment, health, gender, and labour in support of domestic financing aimed at addressing national health workforce priorities;

(5) global health initiatives to ensure that all grants include an assessment of health workforce implications, leverage national coordination and leadership, and contribute to efficient investment in and effective implementation of national health workforce policies;

(OP) 4. REQUESTS the Director-General:

(1) to provide support to Member States, as and when requested, on the implementation and monitoring of the Global Strategy, including to:

(a) optimize their existing health workforce and to anticipate and respond to future health workforce needs;

(b) to strengthen governance and leadership of human resources for health through the development of normative guidance, the provision of technical cooperation, and through the fostering of effective trans-national coordination, alignment, and accountability;

(c) support Member States in developing and maintaining a framework for health workforce information systems, including the consolidation of a core set of health workforce data with annual reporting to the Global Health Observatory, as well as the progressive implementation of National Health Workforce Accounts, in order to strengthen the availability, quality, and completeness of health workforce data;

(d) [additionally support Member States in ensuring the safety of health personnel, including the implementation of preventive measures as called for by United Nation General Assembly resolution 69/132 (2014) on global health and foreign policy];

(2) to include an assessment of health workforce implications of technical resolutions brought before the World Health Assembly and Regional Committees;

(3) to facilitate the exchange of information and good practice on human resources for health and collaboration among Member States and relevant stakeholders, continuing the practices within the WHO Global Code;

(4) to submit a regular report to the World Health Assembly, through the Executive Board, on progress towards the milestones established by the Global Strategy and aligned with reporting on the WHO Global Code.

The CHAIRMAN also drew attention to a draft resolution, sponsored by Andorra, Chile, Estonia, Finland, Japan, Latvia, Liberia, Luxembourg and Thailand, on strengthening integrated, people-centred health services, which read:

The Executive Board,

Having considered the report on the framework on integrated people-centred health services,[1]

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

The Sixty-ninth World Health Assembly,

(PP1) Acknowledging Sustainable Development Goal 3 "Ensure healthy lives and promote well-being for all at all ages" including target 3.8 which addresses achieving universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all;

(PP2) Recalling resolution WHA64.9 (2011) on sustainable health financing structures and universal coverage that calls for investing in and strengthening health-delivery systems, in particular primary health care and services, adequate human resources for health and health information systems, in order to ensure that all citizens have equitable access to health care and services;

(PP3) Reaffirming resolution WHA62.12 (2009) on primary health care, including health system strengthening, requesting implementation plans for four broad policy directions, including putting people at the centre of service delivery;

(PP4) Recalling resolution WHA63.16 (2010) on the WHO Global Code of Practice on the International Recruitment of Health Personnel and its recognition that adequate and accessible health workforce is fundamental to an integrated and effective health system and for the provision of health services;

(PP5) Recalling resolution WHA66.23 (2013) on transforming health workforce education in support of universal health coverage, and WHA64.7 (2011) on strengthening nursing and midwifery which emphasize the implementation of strategies for enhancement of interprofessional education and collaborative practice as part of people-centred care;

(PP6) Reaffirming resolution WHA60.27 (2007) on strengthening health information systems, recognizing that sound information is critical in framing evidence-based health policy and making decisions, and is fundamental for monitoring progress towards internationally agreed health-related development goals;

(PP7) Recalling resolutions WHA67.20 (2014) on regulatory system strengthening for medical products, WHA67.21 (2014) on access to biotherapeutic products, including similar biotherapeutic products, and ensuring their quality, safety and efficacy, WHA67.22 (2014) on access to essential medicines, and WHA67.23 on health intervention and technology assessment in support of universal health coverage;

(PP8) Having considered the report by the Secretariat on the framework on integrated, people-centred health services,

(OP) 1. ADOPTS the framework on integrated, people-centred health services;

[1] Document EB138/37.

(OP) 2. URGES Member States:

(1) to implement proposed policy options and interventions for Member States in the framework on integrated, people-centred health services in accordance with nationally set priorities towards achieving and sustaining universal health coverage;

(2) to make health care systems more responsive to people's needs, preferences and expectations, while recognizing their rights and responsibilities with regard to their own health and engage stakeholders in policy development and implementation;

(3) to promote coordination of health services within the health sector and intersectoral collaboration in order to address the broader social determinants of health and to ensure a holistic approach to services, including health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services;

(OP) 3. INVITES international, regional and national partners to take note of the framework on integrated, people-centred health services;

(OP) 4. REQUESTS the Director-General:

(1) to provide technical support and guidance to Member States for the implementation, national adaptation and operationalization of the framework on integrated, people-centred health services;

(2) to ensure that all relevant parts of the Organization, at headquarters, regional and country levels, are aligned, actively engaged and coordinated in promoting and implementing the framework on integrated, people-centred health services;

(3) to perform research and development on indicators to trace global progress on integrated people-centred health services;

(4) to report progress on the implementation of the framework on integrated people-centred health services to the Seventy-first and Seventy-third World Health Assemblies and at regular intervals thereafter, through the Executive Board.

The financial and administrative implications of the draft resolution for the Secretariat were:

Resolution: Strengthening integrated, people-centred health services
A. Link to the general programme of work and the programme budget
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted. Twelfth General Programme of Work, 2014–2019: Through its mapping of strategies for more integrated and effective services, expansion of services to underserved populations and support for the systems underpinning health security at the country level, the resolution will contribute to the following impacts: reducing under-5 child mortality; reducing maternal mortality; reducing premature mortality from noncommunicable diseases; preventing death, illness and disability arising from emergencies; and reducing rural-urban difference in under-5 mortality. Programme budget 2016–2017: Output 4.2.1 Equitable integrated, people-centred service delivery systems in place in countries and public health approaches strengthened; Output 4.2.2 Health workforce strategies oriented towards universal health coverage implemented in countries; and Output 4.2.3 Countries enabled to improve patient safety and quality of services, and patient empowerment within the context of universal health coverage.

2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.

Not applicable.

3. What is the proposed timeline for implementation of this resolution?

The resolution will support the implementation of the Framework on integrated people-centred health services, 2016–2026.

If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.

B. Budgetary implications of implementation of the resolution

1. Current biennium: estimated budgetary requirements, in US$

Level	Staff	Activities	Total
Country offices	0	5 000 000	5 000 000
Regional offices	550 000	400 000	950 000
Headquarters	550 000	1 015 000	1 565 000
Total	1 100 000	6 415 000	7 515 000

1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)

Yes.

1(b) Financing implications for the budget in the current biennium:

– How much is financed in the current biennium?

US$ 0.94 million

– What are the gaps?

US$ 6.575 million

– What action is proposed to close these gaps?

The funding gap will be tackled as part of the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2016–2017.

2. Next biennium: estimated budgetary requirements, in US$

Level	Staff	Activities	Total
Country offices	0	4 200 000	4 200 000
Regional offices	550 000	400 000	950 000
Headquarters	550 000	1 015 000	1 565 000
Total	1 100 000	5 615 000	6 715 000

2(a) Financing implications for the budget in the next biennium:

– How much is currently financed in the next biennium?

0

– **What are the financing gaps?**

US$ 6.715 million

– **What action is proposed to close these gaps?**

The funding gap will be tackled as part of the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2018–2019.

The representative of BRAZIL said that the draft global strategy on human resources for health should take into account the context of regions' health systems and countries' priorities for health system strengthening. The draft global strategy would support policy-makers and serve as a tool for monitoring national and regional processes. Its categorization of countries was not the best way to organize countries' needs, however. The draft global strategy required further analysis and the draft resolution further consideration.

The representative of the RUSSIAN FEDERATION welcomed the draft global strategy. However, annual reporting, as proposed in the accompanying draft resolution, could be a burden for some Member States; the draft resolution therefore required further work.

The representative of the REPUBLIC OF KOREA said that, in the interests of sustainability, implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel (WHO Global Code) should be accelerated. The Western Pacific Region had increased its capacity to implement the WHO Global Code in the second reporting period.

The representative of the UNITED STATES OF AMERICA expressed support for all the documents under the item. With regard to the draft framework on integrated, people-centred health services, he said that access to health services should respond to life-course needs and preferences and be coordinated, safe, effective and of good quality. His Government remained committed to shifting from fragmented hospital-based models towards strengthened systems centred on people, families and communities and targeting prevention and primary care. Within the draft global strategy on human resources for health, the objectives on capacity building for data collection and analysis and evidence-based planning should be strengthened. The draft global strategy's guiding principles should use language consistent with the goal of promoting the right to enjoyment of the highest attainable standard of physical and mental health. He supported the WHO Global Code and applauded efforts to revise its national reporting instrument to strike a balance between ease of use and the provision of sufficient data. The low number of countries that had provided data in response to the periodic reporting recommendations was a source of concern; WHO should continue to provide technical assistance in that regard where needed.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND also supported all the documents under the item. Her Government was strongly committed to strengthening health systems and recognized that human resources for health played a critical role in that respect, and in respect of achieving Sustainable Development Goal 3. The Secretariat should clarify how the strategy's metrics would be finalized and monitored, and should amend the text to take into account the concerns expressed by the representative of Brazil. With regard to the draft framework on integrated, people-centred health services, she agreed with the comments by the representative of the United States of America.

The representative of CHINA welcomed the reports and draft resolutions. The draft global strategy should take into account countries' varying stages of development and emphasize the need to establish information systems to collect workforce data. WHO should provide more assistance in that

regard. In addition, the draft global strategy should include information on how to balance resources among countries, in order to improve the distribution of the health care workforce. With regard to the draft framework on integrated people-centred health services, immediate and long-term strategies should be identified to ensure its implementation.

The representative of NEW ZEALAND said that his Government supported workforce development that strengthened the role of nurses and health care workers in delivering primary care. The regulation and oversight of health care workers was essential in order to ensure quality education programmes, safe working environments, competent practitioners, public protection and enhanced public health, and thereby to maximize the benefits of universal health coverage. The Secretariat should amend the draft global strategy to place greater pressure on Member States to increase funding for the education of nurses and other health care workers and the introduction of professional regulation and oversight.

The representative of JORDAN, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the strategies of the draft framework on integrated, people-centred health services should be linked to the challenges faced by countries, and in particular those experiencing conflict and low- and middle-income countries. The concept of universal health coverage should be explained more clearly; it was important to send a clear message to decision-makers and provide practical information that would help them to implement programmes. The capacity of institutions to boost public–private partnerships should be strengthened and personnel should be trained through international cooperation.

The representative of NAMIBIA, speaking on behalf of the Member States of the African Region, welcomed the draft global strategy, which would play a pivotal role in the implementation of the health-related Sustainable Development Goals. The burden of communicable diseases in Africa, coupled with noncommunicable diseases, urbanization and demographic trends, called for accelerated efforts and substantial investment in health workforce development. The draft global strategy should refer more clearly to occupational health and safety and programmes for employee well-being, in order to create an enabling environment and better working conditions. An area of concern in that regard was many African countries' low level of financial allocations to health and the need for greater investment in health systems to cap losses from migration. The private sector should be given greater responsibility for training health workers, which must be viewed as an investment, rather than a burden. Clear reporting indicators were needed to monitor implementation of the draft global strategy. The Board should submit the draft global strategy to the Sixty-ninth World Health Assembly.

She welcomed the draft framework, which should underscore a comprehensive community-based approach to health care with prevention and health promotion as key components and health districts as fundamental units in its implementation. Monitoring and evaluation should be emphasized in the framework and funding disparities between curative and public health interventions addressed. The draft framework should be revised to emphasize that the provision of health services should be based on need and the public interest, and not on individual preference, as implied in the current draft. The framework should be more explicit about the considerable efforts needed at the country level to manage change, reorganize front line service provision and improve the patient experience – which would require more work on process re-engineering, skills development and the establishment of multidisciplinary teams. The draft framework should be submitted for approval to the Sixty-ninth World Health Assembly.

The representative of CANADA supported the thrust and intent of the draft global strategy. The language used concerning the earmarking of 25% of health sector development assistance for human resources for health should be adjusted, as earmarking was not desirable and the percentage was an arbitrary ceiling that did not allow donors and country partners to respond to need. A strategic

approach should be taken to integrating the social determinants of health in the education of health professionals. He was in favour of recommending to the Sixty-ninth World Health Assembly the adoption of the draft global strategy. With regard to the draft framework, health care systems should empower citizens, facilitate continuity and coordination of care and address inequitable access. He supported the recommendation that the draft framework should be forwarded for review by the Sixty-ninth World Health Assembly and took note of the corresponding draft resolution.

The representative of LIBERIA, noting that the draft framework attempted to take a holistic approach to health services, called on the Board to adopt the corresponding draft resolution and thereby to recommend its adoption by the Sixty-ninth World Health Assembly.

The representative of KUWAIT welcomed the draft global strategy on human resources for health. With regard to the draft framework on integrated, people-centred health services, she highlighted the need to take into account the fact that financial considerations were a key factor in the emigration of human resources for health. Scientific considerations should also be taken into account. The regional committees and the countries concerned should be responsible for determining needs with regard to human resources for health.

The representative of THAILAND welcomed the draft global strategy and the draft framework. Both needed to be implemented to achieve quality services as part of universal health coverage. She supported the corresponding draft resolutions and expressed concern at the number of WHO global strategies that had not been successfully implemented; a new way of thinking was needed to achieve the health-related Sustainable Development Goals.

The representative of the DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA expressed his interest in the draft framework, since the motto of his Government was "people-centred". Health care in his country was provided free of charge and doctors were committed to working with full dedication. He was against the commercialization of medical services and the lucrative nature of health care. He urged WHO to promote and support countries to move to people-centred health services that were fuelled by compassion, rather than by money.

The representative of ARGENTINA said that the implementation of the draft global strategy would help strengthen health systems and assist in meeting the health-related Sustainable Development Goals. She supported the comments by the representative of Brazil on the categorization of countries and noted that the strategy required further analysis by the Secretariat.

The representative of EGYPT expressed support for the adoption of the draft global strategy and the application of the WHO Global Code. It was important to develop the health workforce by promoting education and training at all levels. He drew attention to the issue of equity in the distribution of the health workforce, which should be based on need, rather than ability to pay, train, educate and hire. Low- and middle-income countries were clearly less privileged in that regard and suffered from brain drain. Increasing the quantity and quality of the health workforce would help to tackle increased demand for health services due to ageing and population changes.

The representative of SWEDEN, speaking on behalf of the Nordic and Baltic countries Denmark, Estonia, Finland, Iceland, Latvia, Lithuania, Norway and Sweden, said that her group of countries had committed to making health systems more responsive to peoples' needs, preferences and expectations. Furthermore, the European Region was discussing a regional framework for integrated health services and she would be willing to share experience on that matter. She asked for clarification of whether the global strategy on integrated, people-centred health services discussed by the regional

committees had evolved into the draft framework on integrated people-centred health services under consideration, or whether that global strategy remained a separate document. Given the lack of agreed indicators on people-centred health services, she encouraged WHO to work with the scientific community and relevant international organizations to develop indicators that would not place an unnecessary reporting burden on Member States. She supported WHO's work on integrated, people-centred health services.

The representative of the REPUBLIC OF KOREA expressed the hope that the draft global strategy would provide an effective solution for the mismatch between health demand, supply and need and would tackle workforce migration issues. Countries should ensure the maximum possible use of cost-effective measures to deliver health services and should implement the draft framework through health system strengthening that targeted primary care. Greater capacity for health care work and providing patient-centred services would be a big step towards universal health coverage. She was ready to share methods and strategies for improving health care work and accumulating evidence-based data.

The representative of JAPAN endorsed the draft resolution on integrated, people-centred health services, which Japan, a strong proponent of health system strengthening, had sponsored. Health services could become fragmented if health systems were provider-oriented. The draft framework set out suitable strategies for establishing a health service system able to cope in the long term with issues such as ageing and rising health care costs according to the context in each country. A phased approach was needed to ensure implementation of those strategies, and the Secretariat should provide Member States with ongoing technical support to that end. It was not clear, however, how implementation would be monitored or achievements measured, and timely action was therefore required to research and develop indicators.

The representative of the PHILIPPINES endorsed the draft framework, which was comprehensive and provided a good reference for health system reform; her delegation stood ready to continue discussing the accompanying draft resolution, which it supported, with a view to making it stronger. She wondered to what extent the various strategies, frameworks and action plans adopted were translated into action at the country level, where they were needed most. Given the financial and human resource implications of preparing and implementing such tools, it was in the interest of the Board to ensure that decisions made by the governing bodies were effectively implemented in the countries concerned. Unfortunately, initial interest in pursuing such decisions tended to gradually wane as more urgent issues arose. That should not be allowed to happen in the case of the draft framework currently before the Board.

The representative of ZIMBABWE, invited to take the floor by the CHAIRMAN at the request of the representative of GAMBIA, said that an efficient, well-resourced and experienced health workforce was key to achieving the health-related Sustainable Development Goals, attaining universal health coverage, implementing primary health care and building strong health systems. His delegation welcomed the draft global strategy on human resources for health: workforce 2030, and, together with its cosponsors, had submitted the draft resolution to promote its adoption and implementation. The draft global strategy differentiated between high-, middle- and low-income countries, yet collaborative linkages would still be needed across those groups. Migration by health workers continued to confound national efforts to educate and retain a health workforce, despite the commitment by Member States in 2010 to implement the WHO Global Code. Indeed, the projection that sub-Saharan Africa would be short up to 3.7 million skilled workers by 2030 was a stark reminder of the enormous amount of work that remained to be done. Win-win partnerships had to be established between source and destination countries, to ensure that adequate numbers of health workers were trained in source countries, while allowing destination States to tap into that resource without depleting it. At the

country level, a multisectoral approach was needed to improve the motivation of the health workforce, and a whole-of-government approach to promote equitable distribution and retention of health workers in urban and rural areas.

The draft resolution was intended to encourage greater political will and investment in human resources for health, to establish linkages with other relevant sectoral plans, and to support the implementation and review of the draft global strategy by a diversity of stakeholders. The draft global strategy required further revision; the Executive Board should therefore mandate the Secretariat to put in place a process to finalize it and the accompanying resolution prior to the Sixty-ninth World Health Assembly in May 2016.

The representative of SURINAME said that, in Suriname's experience, producing a health workforce that was responsive to the needs of the population would require, above and beyond interaction between the education and the health sectors, intensive cooperation towards a mutual goal and the extensive involvement of government and civil society.

The representative of LIBERIA, speaking on behalf of the Member States of the African Region, said that the words "preferences and expectations" should be deleted from paragraph 2 of the draft resolution on strengthening integrated, people-centred health services.

The representative of SWITZERLAND[1] welcomed the increase in the number of country reports on implementation of the WHO Global Code and in the number of national authorities appointed. It was important to pursue those efforts and link them to the draft global strategy. It was also important that the information provided by countries be made available on the WHO website, in order to promote exchanges on the subject and identify best practices. She welcomed the closer cooperation with OECD, in particular the establishment of a module on the migration of health workers, and applauded the introduction of a section in the questionnaire for other stakeholders wishing to provide information on implementation of the WHO Global Code. The revised version of the draft global strategy should be based on the official United Nations definition of the right to health, and the milestone on attrition should be worded more positively, without reference to a figure, in line with other milestones. She endorsed the proposal made by the representative of Zimbabwe to mandate the Secretariat to put in place a process to finalize the draft global strategy and the accompanying resolution before May 2016.

The representative of CUBA[1] considered that the draft global strategy required further work with a view to strengthening certain points, namely: health worker training in line with the various institutions making up the health system; health worker distribution with a view to meeting needs in the various environments in which they worked; regulations on the migration and movement of health workers; a working environment that promoted high-quality health work and was not predicated on financial incentives alone; health worker training that took account of the requirements demanded of health service providers; the training and organization of volunteer community health workers; the selection of adequate technology in the broad sense, including for organizational and management purposes; and the establishment of primary health care as the basis of preventive health care. She shared the concerns expressed by the representatives of Brazil and Argentina, and asked the Secretariat to provide more detailed information in the draft global strategy with regard to the classification of countries, the classification of chronic emergencies and how and with whom the process of classification would be carried out.

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

The representative of COLOMBIA[1] said that the draft global strategy provided a satisfactory framework for activities relating to human resources for health and served to channel coordination efforts between countries, and between countries and international bodies, towards universal health coverage and improved health. Like previous speakers, she considered that the classification of countries would have to be carefully considered in order to understand the repercussions at all levels, and therefore requested that the draft resolution continue to be discussed with a view to reaching a consensus at the Sixty-ninth World Health Assembly.

The representative of NORWAY[1] recognized the challenges addressed in the draft global strategy, supported its objectives and considered the policy options suggested useful. His delegation was prepared to continue working on the draft resolution, which it had cosponsored, with a view to its adoption by the Sixty-ninth World Health Assembly, and strongly supported retaining the two paragraphs currently in square brackets. United Nations General Assembly resolution 68/98, on the protection of health workers, was highly relevant to WHO in that it clearly framed the matter as a health issue affecting all States in all situations and committed States to take preventive action of various kinds that would fall within the scope of the draft global strategy.

The representative of INDIA[1] expressed support for the draft global strategy, but noted that it failed to mention the continuing medical education required to update and enhance the capacity and capability of health care professionals and workers or the use of modern information and communication technology for teaching and updating skills and knowledge. He also expressed support for the draft framework on integrated, people-centred health services, but noted that the accompanying draft resolution did not mention integrating traditional and complementary medicine into modern health systems or the role of family members in providing health care and their training to that end. In view of those comments, he urged interested Member States to work with the sponsors of the draft resolutions and the Secretariat to further strengthen them and the draft global strategy during the intersessional period before the Sixty-ninth World Health Assembly.

The representative of INDONESIA[1] was convinced that implementation of resolutions WHA64.6 (2011) and WHA66.23 (2013) would serve to fulfil the vision of the draft global strategy to promote accelerated progress towards universal health coverage and the health-related Sustainable Development Goals by ensuring universal access to health workers. Broader understanding of the WHO Global Code had to be promoted in all countries, so as to ensure health workforce sustainability and thereby support health system strengthening.

Regarding the draft framework, he said that, in a context of limited resources, health system strengthening meant reorienting the model of care. The strategic approach would nevertheless vary from country to country, and had to be adapted in each case to the local context, existing barriers, and people's values. He was in favour of submitting the draft framework to the Sixty-ninth World Health Assembly.

The representative of the INTERNATIONAL LABOUR ORGANIZATION, speaking at the invitation of the CHAIRMAN, was encouraged by the action taken to strengthen the nursing and midwifery workforce. The ILO Nursing Personnel Convention, 1977 (No. 149), and its accompanying Recommendation (No. 157) had been ratified by only 41 countries to date, and Member States were therefore encouraged to consider ratification with a view to further strengthening the nursing workforce and nursing services in their countries. She expressed appreciation for the inclusive and intersectoral approach of the draft global strategy; the reference to ethical recruitment and the

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

recognition of health workers' rights, in particular, linked the strategy to Sustainable Development Goal 8, on inclusive economic growth and full and productive employment and decent work for all.

The representative of MEDICUS MUNDI INTERNATIONAL, speaking at the invitation of the CHAIRMAN, welcomed the draft global strategy and the accompanying draft resolution, which urged that adequate financing be made available for human resources in health. Unfortunately, the strategy risked not being implemented owing to the all-too-frequent gap between policies and their implementation. WHO should not rely on a utilitarian view of the role of the health workforce in economic growth and labour markets to drive implementation; instead, the emphasis should be on the intrinsic value of a competent workforce in improving health outcomes and reducing health inequalities. While it was to be applauded that a greater number of countries had identified a national authority for the purposes of the WHO Global Code, the Secretariat's report to the Sixty-ninth World Health Assembly should contain a more comprehensive analysis of the data collected through the national reports. The Code suffered from two fundamental shortcomings: it contained no provisions on compensation and was not a legally binding instrument. Moreover, WHO could do more to promote its implementation, including building capacity in African and Asian Member States and exploring the feasibility of compensation for health worker source countries.

The representative of the INTERNATIONAL COUNCIL OF NURSES, speaking at the invitation of the CHAIRMAN, welcomed the draft global strategy and the draft framework. Stronger health systems could be achieved only by strengthening human resources for health, and that meant investing in nursing and midwifery. Nurses provided over 80% of all health-care services, and would therefore play a critical role in the development, provision and supervision of the draft global strategy and the draft framework. They also played a critical role in health promotion and disease prevention, and their role as coordinators in the health care team, focus on people-centeredness, continuity of care, and comprehensiveness and integration of services were essential contributions to integrated, people-centred health services. She urged WHO and governments to ensure that nurses were involved in every aspect of the policy-making agenda, and to implement the WHO Strategic Directions for Nursing and Midwifery for the period 2016–2020.

The representative of the INTERNATIONAL FEDERATION OF BIOMEDICAL LABORATORY SCIENCE, speaking at the invitation of the CHAIRMAN, noted that up to 80% of a patient's record consisted of data generated in a clinical laboratory by a biomedical laboratory scientist. Clinicians relied on those data to diagnose, treat and monitor patients. It was therefore of paramount importance to train, recruit and retain biomedical laboratory scientists, who were in short supply. Health workforce planning was required to ensure they were available in sufficient number for the health care system. To that end, funding had to be made available for continued learning, and biomedical laboratory scientists had to receive adequate pay. Clinical placements were essential to their education and training, and such positions must be made available in the laboratory.

The representative of the INTERNATIONAL FEDERATION FOR MEDICAL AND BIOLOGICAL ENGINEERING, speaking at the invitation of the CHAIRMAN, highlighted the essential role played by medical devices in respect of communicable and noncommunicable diseases; behind those devices stood biomedical and clinical engineers, physicists and technicians specialized in health care. Indeed, biomedical engineers were indispensable health team members who performed the health care technology assessments needed to select health technologies and interventions for universal health coverage. WHO should therefore acknowledge that biomedical engineers, clinical engineers, medical and radiation physicists and medical technicians were part of the health workforce.

The representative of THE SAVE THE CHILDREN FUND, speaking at the invitation of the CHAIRMAN, welcomed the draft global strategy and its clear plan to drive the health workforce needs for universal health coverage. The economic benefits of having more staff in the health workforce and a healthier population were clear, but it must not be forgotten that, while having access to a trained health worker was a right, all health workers, including community health workers, were entitled to a living wage, safe and decent working conditions and protection from violence. The health worker crisis was a global dilemma, and unless all countries took their responsibilities seriously, universal health coverage for low-income countries would not be achieved, despite the commitments made in the Sustainable Development Goals. Global action nevertheless needed coordination, and he therefore urged that there be ongoing liaison on health workforce policies, closely linked with the new coordination needed to support all aspects of universal health coverage.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS ASSOCIATIONS, speaking at the invitation of the CHAIRMAN, called on Member States to ensure that health workers had access to good-quality education and to proper working and learning conditions. Health workforce planners had to consider not only the number of medical schools, but also the quality of the education they dispensed, and address the specific learning and working conditions of students, the population's needs, and the distribution of the health workforce globally and in rural and urban areas. Medical schools should be properly accredited in accordance with international standards. She also called for comprehensive, timely and adequate health workforce planning, which would require collaboration between all major stakeholders to ensure the implementation of the WHO Global Code.

The ASSISTANT DIRECTOR-GENERAL (Health Systems and Innovation) said that the Secretariat would work with Member States to fine-tune the draft global strategy during the intersessional period before the Sixty-ninth World Health Assembly. She confirmed that the strategy on integrated, people-centred health services had been converted into a draft framework because of the lack of indicators and a monitoring framework, and said that the draft framework was likely to have a long period of application given the momentum behind universal health coverage and health system strengthening.

The CHAIRMAN took it that the Board wished to take note of the reports contained in documents EB138/34 and EB138/35. Having heard the comments on the draft resolution on the global strategy on human resources for health: workforce 2030, he further took it that the Board was of the view that the draft would benefit from informal consultations among Member States during the intersessional period before the Sixty-ninth World Health Assembly, and that it requested the Secretariat to take account of the comments made in preparing the discussion of the item at that Assembly. Lastly, it was his understanding that the Board wished to work further on documents EB138/36 and EB138/37. Having heard no further comments on the draft resolution on strengthening integrated, people-centred health services, he took it that the Board wished to approve the draft resolution as amended.

It was so agreed, and the resolution on strengthening integrated, people-centred health services was adopted as amended.

The meeting rose at 21:10.

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