World Health Organization

**EXECUTIVE BOARD** **EB139/PSR/3**
**139th session** **5 July 2016**

# PROVISIONAL SUMMARY RECORD OF THE THIRD MEETING

**WHO headquarters, Geneva**
**Tuesday, 31 May 2016, scheduled at 09:30**

**Chairman:** Dr R. BUSUTTIL (Malta)

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**THIRD MEETING**

**Tuesday, 31 May 2016, at 09:35**

**Chairman:** Dr R. BUSUTTIL (Malta)

## 1. TECHNICAL AND HEALTH MATTERS: Item 6 of the agenda (continued)

**Health and climate change:** Item 6.4 of the agenda (document EB139/6) (continued)

The representative of MOROCCO[1] expressed support for the strategic priorities proposed in document EB139/6. The Paris Agreement represented a major step forward in recognizing the health impacts of climate change. The health sector should increase its efforts to protect populations and adapt to the unforeseen consequences of climate change. His country, which would host the next session of the Conference of the Parties to the United Nations Framework Convention on Climate Change, was working with international partners to ensure that progress would be made in implementing the Paris Agreement. He welcomed the Organization's efforts to improve health sector access to international funding mechanisms and to become an accredited entity of the Green Climate Fund, which would enable developing countries affected by climate change to access financial support more easily.

The representative of the BOLIVARIAN REPUBLIC OF VENEZUELA[1] emphasized the need for urgent action to tackle climate change and for appropriate indicators to monitor progress. The adoption of the Paris Agreement was only the first step; the political will to take voluntary action in response to the evolving situation would be vital. Common but differentiated responsibilities were important, particularly in the health sector. Expanding the public health response to climate change was a major challenge. He expressed support for the strategic priorities identified in the Secretariat's report but emphasized that they would require close cooperation, coordination and political will, guided by WHO.

The representative of BRAZIL stressed the importance of the Secretariat's report and the proposed strategic priorities contained therein. She emphasized her support for the Organization to act in favour of public health answers to climate change.

The representative of the INTERNATIONAL COUNCIL OF NURSES, speaking at the invitation of the CHAIRMAN, noted with appreciation the Organization's swift response to the Paris Agreement. Nurses played a major role in educating policy-makers and the public about climate change, and in supporting individuals to make healthy lifestyle choices that reduced negative impacts on the environment. Nurses could help reduce waste by advising on the procurement of health goods and services and contribute to making health systems more resilient to climate-induced shocks. Nurses should be included in disaster preparedness teams and involved in developing national action plans and policies. In some areas, rising sea levels would displace nurses from places where they were most needed to respond to the public health impacts of climate change.

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

The ASSISTANT DIRECTOR-GENERAL (Family, Women's and Children's Health), responding to the points raised, emphasized how important it was that the right to health was recognized in the Paris Agreement and that health issues were being taken seriously as an aspect of climate change. The WHO Conference on Health and Climate 2016 would focus on actions that the health sector could take in the areas of adaptation and mitigation, and the Secretariat planned to use it it as a consultation for reviewing and improving the workplan on climate change and health. She acknowledged calls, including from the representative of Fiji, for WHO to support countries in accessing funding. As agreed, regular reports would be submitted to the Board and the Health Assembly on what Member States and the Secretariat had achieved under the workplan.

The representative of THAILAND said that, since it had been agreed not to consider any draft decisions on the agenda item, the Board's summary records should include a clear conclusion to the effect that the Board had agreed to request the Secretariat to revise the approved WHO workplan on climate change and health 2014–2019, taking into account the four strategic priorities proposed in the Secretariat's report, and report to the Seventieth World Health Assembly through the 140th session of the Executive Board.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND asked whether the timeline for reporting suggested by the representative of Thailand was feasible. It had been agreed to report regularly, rather than to a specific session of the Board.

The CHAIRMAN expressed the view that it would be easier to regulate the agendas of the Board and the Health Assembly if no specific time frame was mentioned. He took it that the Board agreed to request the Secretariat to report regularly on progress in implementing the workplan.

**It was so agreed.**

**The Board noted the report.**

**International Statistical Classification of Diseases and Related Health Problems: update on the eleventh revision:** Item 6.5 of the agenda (document EB139/7)

The representative of KUWAIT, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that updating the eleventh revision of the International Statistical Classification of Diseases and Related Health Problems would contribute to implementing the 2030 Agenda for Sustainable Development[1] by strengthening strategic health planning and the optimal use of financial resources for health through the monitoring of morbidity and mortality statistics. He emphasized the scientific basis and the effective electronic environment underpinning the improvements made to the draft revision, and noted that several new health-related fields were addressed, including alternative medicine. His country was working with the Regional Office for the Eastern Mediterranean to establish a Collaborative Centre for international statistical classification, which potentially would be an important tool.

[1] United Nations General Assembly resolution 70/1 (2016).

The representative of COLOMBIA[1] highlighted the importance of revising the Classification. The eleventh revision would enable States to code health information more effectively and better analyse the health situation. It would also improve semantic interoperability. The process of incorporating changes into national systems, however, would take at least five years and require considerable time and investment. The revision should therefore focus on updates that were absolutely necessary. He agreed that the Classification should include information on antimicrobial resistance.

The representative of the NETHERLANDS,[1] speaking on behalf of the European Union and its Member States, expressed appreciation for the eleventh revision of the Classification and noted in particular the emphasis on meeting the needs of statisticians and improving two-way communication with external users. The original plans for the revision had proved over-ambitious, and choices must now be made. Since the Classification was intended for worldwide use, priority should be given to stability and ease of use, rather than sophistication and constant changes. Given the high transition and maintenance costs involved, the new revision must add real value. Mortality statistics should be altered as infrequently as possible, and computerized decision tables for software that automatically coded causes of death must be available before the revision could be considered ready for use. The Secretariat and Member States should agree on a comprehensive project plan for the remainder of the task, with realistic estimates of required and available resources. The new revision should not be submitted to the Health Assembly until its usefulness had been demonstrated. He requested that the Secretariat should report to the 140th session of the Board on the outcome of the International Statistical Classification of Diseases Revision Conference that would be held in Tokyo in October 2016.

The representative of BHUTAN[1] expressed satisfaction at the inclusion of primary health care concepts in the eleventh revision of the Classification and emphasized the importance of a global standard reporting system. Noting that not all Member States currently used the tenth edition of the Classification, he suggested that a mechanism should be established to ensure that all Member States would use the eleventh edition.

The representative of MEXICO[1] agreed that the Classification required revision and welcomed the Secretariat's activities in line with the recommendations of the external review conducted in 2015. He also welcomed the decision to agree a workplan and methodology for pilot projects, which his country planned to carry out in three states. Information on the revision work should be made available in Spanish for health professionals who might not be familiar with the process.

The representative of CHINA asked whether the schedule for releasing the final version of the eleventh revision of the Classification had been confirmed, whether the Secretariat had produced technical and policy guidance for Member States adopting the eleventh revision, and whether the Organization had finished its preparations, especially transitional work. She highlighted the need to focus on the links between the new primary care concepts introduced in the eleventh revision and other classifications, such as the International Classification of Primary Care, second edition. It was also necessary to clarify the relationship between the terminology used in the Classification and in other nomenclatures and coding systems. The report contained in document EB139/7 did not mention the classification of surgical operations, and she asked whether they could be taken into account in the eleventh revision, particularly with regard to terminology.

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

The representative of the CONGO, speaking on behalf of the Member States of the African Region, said that weak health information systems had limited achievements, despite progress having been made in his region in certain areas, such as with data on deaths from communicable diseases. Some States had been unable to keep pace with changes in nomenclature reflecting scientific advances due to inadequate diagnostic capacities. There was still a need for the glossary of neglected tropical diseases, as some of those diseases were re-emerging, while the Classification should retain entries on emerging and traditional diseases. Discussion of the revision within the Organization's regional committees would enable Member States to share any concerns.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND echoed the comments made by the representatives of Kuwait, Colombia, Mexico and others regarding the importance of such work, which only WHO could do. One way to add real value to the eleventh revision of the Classification would be to make the sections on antimicrobial resistance work: current data on health events and deaths relating to antimicrobial resistance were inadequate. Code changes in that respect were essential to ensure that the revision was fit for purpose and could inform all countries' future work in that priority area.

The representative of NEW ZEALAND said that the eleventh revision of the Classification must be simple, relevant and compatible with existing electronic platforms and information technology systems. Revision was needed to reflect the developments and emerging priorities of health systems over past decades. Timely completion and implementation of the project would facilitate high-quality data collection, risk identification and appropriate risk management. Data collection and analysis on issues such as antimicrobial resistance should be prioritized in the revision, since it would add value. Discussion of the Classification should take into account the report on mHealth: use of mobile wireless technologies for public health[1] in light of the need to review terminologies and ontologies to ensure that they integrated with current mobile and electronic health platforms, thus facilitating seamless interconnections between different health information systems.

The representative of NEPAL noted that many Member States continued to face problems in the implementation of the tenth revision of the Classification. Moving to the eleventh revision would therefore be challenging, in particular for developing countries, and require guidance and technical support. The establishment of regional centres of excellence, with networks in individual Member States, might be useful in that regard.

The representative of CANADA said that the Classification was a critical public health tool and the stability of data capture was paramount. The Revision Conference in October 2016 would provide a timely opportunity for Member States to assess whether the tool was ready for field testing and submission to the Health Assembly.

The representative of VIET NAM[2] took positive note of the incorporation in the eleventh revision of diagnostic categories used in traditional medicine; comparability of statistics; functionality in an electronic environment; and the establishment of a multilingual coding platform. When piloting the new instrument, data collection practices in low- and middle-income countries should be taken into account, and improved. A study on the challenges faced by health systems when adopting a new

[1] Document EB139/8.

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

coding system could be useful. The Secretariat should set a timeline for the release of the eleventh revision, and guide Member States in preparing for its implementation.

The representative of THAILAND expressed support for the call by Member States for a simplified, more user-friendly tool, which could be discussed at the Revision Conference. Antimicrobial resistance was a priority and must be incorporated in a more practical manner. It was also important to strengthen countries' capacity to use the Classification to support civil registration and vital statistics. The Secretariat should link its work on the eleventh revision to overall efforts to strengthen health systems and achieve universal health coverage.

The representative of TURKEY[1] said that he welcomed the forthcoming release of the eleventh revision and noted that the tenth revision was widely used and accepted. He supported the call by the representative of China for the new primary care concepts mentioned in the revision to be linked to the International Classification of Primary Care.

The representative of PAKISTAN said that his delegation appreciated the inclusion in the revision of primary care concepts and additional coding options. The inclusion of diagnostic categories used in traditional medicine was also a significant step, although it might be prudent to include broader systems of traditional medicine.

The representative of JAPAN briefed the Board on the financial and technical contributions made by his country to the eleventh revision of the Classification. The new tool reflected advances in medicine, science and technology and the Secretariat should ensure that the revision, which was slightly behind schedule, was completed in a timely manner.

The representative of BANGLADESH[1] said that his country had made considerable progress in using the tenth revision of the Classification and looked forward to the timely completion of the new version. He asked what provisions had been made to ensure smooth data migration from one database to another, and when the final version of the eleventh revision would be available.

The representative of GERMANY[1] said that the tenth revision of the Classification was widely used in her country. She welcomed WHO's efforts to direct the eleventh revision towards the key applications of mortality and morbidity statistics. In order to ensure that the revision met the needs of all countries, it should be thoroughly tested prior to final release.

The representative of NORWAY[1] fully endorsed the statement made by the representative of the Netherlands on behalf of the European Union and its Member States.

The representative of ZAMBIA[1] agreed that surgical procedures should be included in the eleventh revision of the Classification. While the revision had the potential to enhance Member States' capacity to standardize the reporting of vital statistics, Zambia and other countries in his region had encountered difficulties in implementing previous revisions, due to limited availability and a lack of awareness. The eleventh revision should be made widely available and his country stood ready to field-test it prior to the official release.

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

The ASSISTANT DIRECTOR-GENERAL (Health Systems and Innovation), responding to the points raised, said that, in late 2014, WHO had requested an external review of the progress made in revising the Classification; the recommendations emerging from that review had been subsequently implemented. Special attention had been paid to stability, user-friendliness, continuity during transition between the two versions and suitability for all countries. A range of experts had provided input at different stages of the process. Taking note of the proposal to further expand the network of collaborative centres and the request for a report on the Review Conference, she said that the Secretariat would prepare a report on the Review Conference for consideration at the 140th session of the Executive Board. The Organization was collaborating with the International Health Terminology Standards Development Organization to ensure that ICD-11 and SNOMED-CT were interoperable. Coverage of complementary traditional medicines systems would be broadened in the years to come. She confirmed that surgical procedures were classified in the International Classification of Health Interventions. The tenth revision of the Classification already provided codes for antimicrobial resistance and experts were working to further refine those codes. The Organization was working to harmonize the Classification with the International Classification of Primary Care. Use in different languages would be facilitated by a translation platform embedded in the online version of the eleventh revision. While there was a broad focus on meeting statistical needs, Member States could use the Classification for the purpose of health financing. The eleventh revision of the Classification, along with implementation guidance and training material, would be distributed to Member States for comment at the Revision Conference in October 2016. Final release was scheduled for early 2018. The eleventh revision was needed to reflect scientific and medical advances since the Classification's last in-depth revision in 1989. She encouraged Member States to participate in the Review Conference.

**The Board noted the report.**

**mHealth: use of mobile wireless technologies for public health:** Item 6.6 of the agenda (document EB139/8)

The representative of NEPAL said that mobile technology would improve access to health services and health-related information. It could also enhance accessibility for migrant populations and people living in remote areas. Since many countries were moving towards the establishment of eHealth architectures, the discussion of mHealth was highly topical and should be maintained on the Board's agenda.

The representative of the NETHERLANDS,[1] speaking on behalf of the European Union and its Member States, said that mobile technologies could change the way people interacted with health services, accelerate efforts towards achieving universal health coverage, facilitate innovation and improve health outcomes. The use of mobile devices brought eHealth services closer to the people. Cooperation was needed on issues such as interoperability, evidence gathering, awareness-raising, improvement of digital skills, data validity and privacy. Data access and sharing were crucial to reaping the benefits of eHealth services. He urged WHO to continue its work on mHealth and migrant health and noted the need for all Member States to assess, scale-up and integrate mHealth solutions.

The representative of MEXICO[1] observed that mobile technologies were increasingly relevant to health care delivery. Cooperation with the telecommunications sector was crucial. It was also important to train health workers in the use of mobile technologies. Taking note of the report, he

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

requested that future reports should address progress made with regard to resolution WHA58.28 (2005) on eHealth, and resolution WHA66.24 (2013) on eHealth standardization and interoperability.

The representative of COLOMBIA[1] noted that the use of mobile technologies in public health was important to remote access, real-time communication and the bilateral exchange of information. The Organization should give high priority to the issue of mHealth, since it presented a great opportunity to improve access to quality health care.

The representative of the DEMOCRATIC REPUBLIC OF THE CONGO, referring to his country's experience with eHealth and mHealth, said that the project had met with many of the problems described in the report. Cooperation with the telecommunications sector, partners and donors had been vital to the successful implementation of eHealth and mHealth software.

The representative of TURKEY[1] said that the health community should use the opportunity presented by the ready availability of mobile telephones. Although it was difficult to monitor, scale-up and assess the comparative value of mHealth solutions, the initiatives that had been developed were promising.

The representative of CHINA said that more comprehensive data availability was crucial to boosting Member States' capacities to analyse and use data, and to improving human health. Spatial and geographic information technologies could play a key role in managing health emergencies, disease surveillance and control, and medical resource planning. Member States' investments in those technologies should be increased. The Secretariat should provide technical guidance to facilitate the sharing of information and evidence among Member States.

The representative of BHUTAN[1] said that the use of information and communications technology, especially mobile technology, would improve health care delivery and efficiency and help tackle the health care workforce gap. The Organization should support the development of easy and reliable mobile applications and help Member States in the South-East Asia Region scale-up mHealth initiatives.

The representative of LIBERIA, speaking on behalf of the Member States of the African Region, said that eHealth systems and services were essential to current and future health care. In her region, mHealth could promote a stronger, more people-centred health service delivery, including improved health care coverage, electronic registry and patient empowerment. While noting the obstacles to a more comprehensive application of mobile health services, she fully supported WHO's new priorities in the area of mHealth.

The representative of THAILAND said that, while mobile technologies offered many benefits, the inappropriate and excessive use of such technologies could be detrimental to public health. Dissemination of information, including the inappropriate marketing of medicines, was largely unregulated. International guidance and regulatory mechanisms were therefore crucial. The Organization should promote the appropriate use of mobile technologies and mitigate their adverse impacts on public health.

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

The representative of the UNITED STATES OF AMERICA expressed support for the expansion of digital technologies to help achieve the Sustainable Development Goals. Public–private partnerships could be particularly advantageous, given the private sector's considerable expertise in mobile technologies.

The representative of NEW ZEALAND said that flexible, future-based information technology architecture and standard health care terminology were crucial to systematic data processing and reaping the benefits of eHealth and mHealth solutions. The Organization should work with partners to review the lessons learned by Member States using mHealth systems and set standards and terminology that could be applied by all Member States, in order to leave no one behind. The issue of mHealth should be prioritized in the "rolling agenda" for the 140th session of the Executive Board.

The representative of PAKISTAN said that further research should be conducted on the potentially harmful effects of mobile technology, with a view to ensuring that mHealth measures were useful. Resources would be required to continuously review that research and to develop relevant strategies and mitigation measures. Research was also needed on the cost–effectiveness of different communication methodologies.

The representative of BANGLADESH[1] explained that mobile technologies had been used to introduce an eHealth system in his country, which was a world leader in the field of mobile health technology. He offered the open source solutions used in his country to other Member States, free of charge, and expressed his willingness to share his country's experience of building an effective eHealth network. He supported the proposal by the representative of India to submit a draft resolution on mHealth for adoption at the Seventieth World Health Assembly.

The representative of ZAMBIA[1] reaffirmed the value of the appropriate use of mobile technology for public health service delivery in respect of universal health coverage. The use of mHealth solutions in his country included a pilot of the mCervicalCancer tool.

The representative of SOUTH AFRICA said that, given rapid developments in respect of mHealth, standard-setting was required and efforts should be made to optimize the use of data to enhance service delivery.

The representative of INDIA[1] said that the prevalence of mobile telephones, even in poor and remote areas, meant that mHealth could strengthen health systems and revolutionize the way populations interacted with national health services. It was therefore important to move beyond pilots and address sustainability and scalability to mainstream mHealth in the health sector. The Organization must develop evidence-based guidance on the use of mHealth so that Member States could make good investment decisions. It should also facilitate the sharing of evidence, best practices and experience in mHealth implementation and provide technical assistance in developing related national strategies. He proposed the submission of a draft resolution on mHealth for adoption at the Seventieth World Health Assembly.

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

The representative of KENYA[1] noted that eHealth provided essential infrastructure and acted as a driver of improved health outcomes. It was crucial to support ongoing efforts in mHealth and encourage the sharing of best practices and lessons learned. Challenges in standardization should be addressed to ensure interoperability and consistency.

The representative of BRAZIL said that, in order for mHealth to prosper, Member States would have to increase bandwidth availability and promote affordable mobile telephone data plans. The Organization should cooperate with international and national entities, such as ITU and ministries of health and communications to develop better access to mHealth services and treatment. Interoperability was necessary for seamless operating, since mHealth initiatives could be geared towards a variety of domains. There must be a balance between patients' privacy and the objectives of interoperability and the appropriate use and quality control of health expertise. Policies on access to personal health data, including by insurance companies, could need further consideration at the international level and enforcement at the country level to ensure ethical and appropriate behaviour. He supported a broader role for WHO in that connection, in consultation with Member States.

The ASSISTANT DIRECTOR GENERAL (Health Systems and Innovation) highlighted the important role of mHealth in revolutionizing health service access and delivery. Remaining challenges included the spread of pilot projects that lacked adequate evaluation, standard-setting or the applicaton of a multisectoral approach. The Organization had taken steps to improve data availability, for example, by establishing the Global Observatory for eHealth and working with ITU. She took note of the points raised, particularly the need to consider links between migrant populations and the eHealth agenda, and to build more evidence with respect to the role that mHealth could play in health service delivery at the country level.

**The Board noted the report.**

## 2. MANAGEMENT AND FINANCIAL MATTERS: Item 7 of the agenda

**Evaluation: annual report:** Item 7.1 of the agenda (document EB139/9)

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND requested an update of progress and any reprioritization of activities. She welcomed the launch of the Evaluation Office's e-newsletter and encouraged WHO to continue holding information sessions. Organizational learning was crucial and evaluation recommendations must be fully implemented. Systems should be developed to institutionalize shared learning across the three levels of the Organization. A tool should be introduced to monitor the implementation of recommendations.

The representative of SWEDEN said that transforming evaluation into organizational learning was central to improved management. Strong engagement from staff was also pivotal. She requested more information on how organizational learning was ensured and on the challenges and progress thus far. She reiterated the request that future reports should include more in-depth information about the steps to be taken to implement the recommendations.

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

The representative of the UNITED STATES OF AMERICA expressed support for the work on evaluation performed by the Organization and welcomed WHO's membership of the United Nations Evaluation Group. The evaluation of WHO's presence in countries was of particular interest. He called for long-term, systematic follow-up to the recommendations of that evaluation as a key element in WHO reform.

The representative of THAILAND expressed support for the statement by the United Kingdom of Great Britain and Northern Ireland. Evaluation should be included in the planning stage of WHO strategies and action plans to ensure realistic expectations and improve implementation. She expressed concern about the roll-over of evaluations from previous workplans, which should be improved in current workplans. Evaluations should be carried out in an independent, accountable and transparent manner, and add value to the planning process. The framework for strengthening evaluation and organizational learning in WHO was an example of good governance.

The representative of SWITZERLAND[1] said that collaboration between Member States and the Secretariat to carry out evaluations on cross-sectoral themes could help monitor progress related to core voluntary contributions. It could also contribute to the evaluation of cooperation strategies and feed into the work of regional committees. Peer evaluation should be used in all WHO operational units and its results made accessible to internal and external stakeholders. Evaluation should be included in the workplan of each unit and project, and sufficiently provided for in budgets.

The REPRESENTATIVE OF THE DIRECTOR-GENERAL (Evaluation and Organizational Learning) said that the evaluation workplan for 2016–2017 was ambitious. He confirmed that the Secretariat would provide updates on progress and on any reprioritization at the next session of the Executive Board. Efforts were being made to achieve organizational learning outcomes by including staff in evaluation management groups and in WHO's Global Network on Evaluation, thereby seeking to develop an evaluation culture throughout the Organization. Involvement in evaluation was also achieved through the preparation of workplans, and an increased number of staff had participated in the process for the 2016–2017 biennium. In addition to the summaries of 13 evaluations mentioned in the Secretariat's report, full evaluation reports were available on WHO's website. He concurred with the need to give priority to evaluation in both planning and budgeting procedures.

The DIRECTOR-GENERAL said that evaluation should be part of the Organization's "DNA". One of the main lessons drawn from her own training could be summarized by "PIE" – an acronym that referred to planning, implementation and evaluation. Those three steps should be applied to all the Organization's work and she would continue working with the Evaluation Office to make that a reality.

**The Board noted the report.**

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

**Committees of the Executive Board: filling of vacancies:** Item 7.2 of the agenda (documents EB139/10 and EB139/10 Add.1)

The CHAIRMAN recalled that, following the adoption of the Framework of Engagement with Non-State Actors by the Sixty-ninth World Health Assembly, the Standing Committee on Nongovernmental Organizations would cease to exist. He accordingly invited the Board to adopt the following decision:

> In accordance with the adoption by the Sixty-ninth World Health Assembly of the Framework of Engagement with Non-State Actors, the Executive Board, through the Programme, Budget and Administration Committee, will conduct the review of any Non-State Actors applying to be in official relations, as well as the review of renewals.

**The Board adopted the decision.**[1]

- **Programme, Budget and Administration Committee**

The CHAIRMAN said that the Programme, Budget and Administration Committee was composed of 14 members: two from each region from among Board members, plus the Chairman and the Vice-Chairman of the Executive Board, members ex officio. There were six vacancies to be filled on the Committee. He asked whether the Board approved the proposals contained in paragraph 2 of document EB139/10 Add.1, as amended.

**It was so decided.**[2]

- **Foundation committees and selection panels**

The CHAIRMAN said that there were four vacancies to be filled on the foundation committees and selection panels, and asked whether the Board approved the proposals contained in paragraph 2 of document EB139/10 Add.1.

**It was so decided.**[3]

- **Appointment of representatives of the Executive Board to the Seventieth World Health Assembly**

The CHAIRMAN proposed that the Executive Board be represented by the Chairman and the first three Vice-Chairmen. If any of them were not able to attend the Health Assembly, the other Vice-Chairmen and/or the Rapporteur could be asked to represent the Board. In the absence of any objections, he took it that the Board wished to approve that proposal.

**It was so decided.**[1]

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[1] Decision EB139(2).

[2] Decision EB139(3).

[3] Decision EB139(4), decision EB139(5), decision EB139(6) and decision EB139(7).

**Process for the election of the Director-General of the World Health Organization: date of the candidates' forum:** Item 7.3 of the agenda (document EB139/11)

The CHAIRMAN recalled that an electronic voting system would be used to vote for the next Director-General at the 140th session of the Executive Board. Testing of the new system had raised a number of procedural concerns. In order to achieve clarity with respect to the procedure, he invited the Board to agree on a number of terms. Firstly, and with regard to the shortlisting phase, decision EB100(7) (1997) indicated that "any candidates not having received a minimum proportion of the votes cast (set at 10% of the ballot papers)" would be eliminated. The terms "votes cast" and "ballot papers" should be understood as "members present and voting", in accordance with rule 42 of the Rules of Procedure. The Secretariat would use that figure when calculating 10% for the application of the rule. For the sake of clarity, the 10% threshold would be regarded as having been attained by a candidate if they secured three votes when the number of Members present and voting was between 21 and 30 (inclusive), and four when the number of Members present and voting was between 31 and 34 (inclusive). Secondly, in the nomination phase, it was possible for more than three candidates to secure the simple majority of the Members present and voting required by the Rules of Procedure in the first round of voting, although only three places were available on the nomination list. The rules did not offer clear instructions for such situations and he therefore proposed that, if the situation arose, the interpretation set out in the United Nations model rules should be followed. They provided that:

> "When one or more elective places are to be filled at one time under the same conditions, each delegation entitled to vote may cast a vote for as many candidates as there are places to be filled, and those candidates, in a number not exceeding the number of such places, obtaining in the first ballot a majority of the votes cast and the largest number of votes shall be elected."
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> Thirdly, under Rule 42 of the Rules of Procedures, with regard to who was counted as absent or abstaining by the electronic voting system, the system provided an option to cast a vote as an abstention and only those votes would be registered as such. The electronic voting system would count a Member as not present for the purposes of the vote if they did not collect a touchpad and personal identification number, if they did not enter their personal identification number into the system, or if they did not vote while voting was open. Any such Members would be displayed as having been "absent" on the results sheet produced by the electronic voting system.

The representative of THAILAND noted that only three official candidates had applied so far. It was hoped that more candidates would come forward prior to the candidates' forum. She requested clarification of the reasons for not holding the forum one day earlier.

The LEGAL COUNSEL said that the date of the candidates' forum had been decided according to the availability of appropriate facilities for the vote.

**The Board noted the report, agreed to the terms outlined by the Chairman to clarify the procedures, and approved the draft decision.**[2]

[1] Decision EB139(8).

[2] Decision EB139(9).

**Staffing matters: statement by the representative of the WHO staff associations:** Item 8 of the agenda (document EB139/INF./1)

The representative of the WHO STAFF ASSOCIATIONS, speaking on behalf of the staff associations of WHO, UNAIDS and IARC, presented the statement. The full version could be found online and had been made available to the Programme, Budget and Administration Committee prior to the session of the Executive Board in order to guide the Committee's decision-making processes, a practice that would be continued in the future. She laid particular emphasis on the staff associations' request for an Executive Board resolution that would permit a staff representative to contribute verbally to the proceedings of the Programme, Budget and Administration Committee. That would be a mutually beneficial arrangement in line with modern participatory management approaches.

Staff and management had continued to work well together in a number of areas. Staff had been encouraged to see that the results of the recent survey on respect in the workplace had been taken seriously by senior management, which should be seen as a continuous process, in order to achieve lasting positive effects. There had been a positive reaction to the first annual mobility exercise. The staff associations supported the principle of mobility, on the premise that it would be carried out in a manner that would be mutually beneficial to the Organization and its staff. A survey on mobility had indicated that staff were in favour of the initiative yet remained concerned at the lack of incentives, gender equity, spousal employment and other support measures. Requests to make the scheme voluntary mainly came from women, and only one out of three applicants for the first exercise were female. Staff considered that the exercise could enhance the performance of WHO as a whole by making best use of existing expertise. Recalling that staff representatives had attended the first meeting of the Global Mobility Committee as observers, she reiterated the request that they should be given full membership status, as equal partners in the process.

With regard to internal justice procedures, much valuable work had been put into strengthening formal rather than informal channels. Formal mechanisms included the Global Board of Appeal, which had been established in Budapest following the merger of the regional boards of appeal and the introduction of mandatory administrative review. Although those were important mechanisms, the strong focus on formal processes had led to the escalation of many cases and increased time and costs. A large number of internal appeals had been filed against WHO with the ILO Administrative Tribunal, with serious financial and reputational implications for the Organization. Most of the cases brought against WHO related to contractual issues, post abolitions and the establishment of work-related diseases. Six cases involving charges of harassment had been won or partially won by the complainants, although the same cases had been judged not to have constituted harassment by the internal justice bodies. Given the policy of zero tolerance for harassment, those cases were unacceptable, especially considering that they were only the tip of the iceberg. Early intervention measures were urgently needed to strengthen preventive approaches, and she strongly recommended hiring professional, dedicated and accredited ombudspersons and mediators in the regions to address conflict at its early stages. Furthermore, the creation of an internal coordinating body tasked with analysis and problem-solving would be highly beneficial and would fit well into the internal auditor's reporting on the performance of different technical departments.

The representative of the UNITED STATES OF AMERICA said that he commended the staff associations for their proactive communication efforts and WHO staff worldwide for their adjustment to change under WHO reform, while maintaining their high productivity and strong dedication. While there had been a positive reaction to the mobility programme, the number of participants remained far below target, calling for further consideration of how to get the best from staff. He counselled caution with regard to changing the status of staff representatives on the Global Mobility Committee. Although inclusion and engagement should be promoted, any conflict of interest should be avoided. Decisions should be reached on the basis of evidence and through transparent procedures. He

expressed concern that the majority of internal appeals concerned contractual issues and the abolition of posts, and called for measures to ensure that contractual conditions were honoured.

The representative of SWEDEN took positive note of the statement, in particular staff and management initiatives on gender equality. She accorded particular priority to the effective implementation of emergency reform and agreed that the staff associations should be an active and equal partner in the proposed task force on staff issues related to the emergency reform. She expressed concern at the high number of internal appeals filed against WHO with the ILO Administrative Tribunal, pointing to systematic practices in certain departments, and supported the auditing of the departments and clusters with the highest number of internal appeals. She reiterated her Government's call for the full and timely implementation of the mobility scheme, which was a fundamental part of WHO reform and necessary to making the Organization fit for purpose. Staff representatives should have a key role in that regard, and concerns raised by staff should be addressed to the fullest extent possible.

The representative of MEXICO[1] noted that the full participation of staff in the proposed task force on staff issues related to the emergency reform could be important for ensuring harmonization of the programme, evaluating and approving the capacities within the current platform, reducing staff costs, and satisfying the need for WHO reform. He also valued the role of the staff associations in the implementation of the mobility programme and the request that staff representatives should be included in the Global Mobility Committee. There should be a transparent process to guarantee the independence of the chair and vice-chair of the future Global Board of Appeal. In addition, Member States wanted to know the financial and strategic implications of changes to the Staff Regulations.

The representative of THAILAND said he would fully support the proposal of the staff associations with one condition: that the staff proved to the Executive Board that they were "good", that is, that they were there for the public interest, not for their own interests. WHO's only power was "soft" power, which meant it needed people's trust. Trust in the Organization depended on the integrity and intellectual capacity of its staff. He welcomed the determination of the Director-General and his own Regional Director to adopt a robust, transparent and accountable recruitment system. Through the Chairman, he therefore asked the staff associations to help ensure that all staff had great integrity.

The representative of BRAZIL recalled that, during his country's membership of the Board, it had raised the issue of staff representation in the governing bodies because good interaction with staff and enabling them to express their priorities, expectations and concerns was the best way to carry forward WHO's work. His experience of WHO staff had been entirely positive. He was in favour of full staff representation on the Global Mobility Committee. The Framework of Engagement with Non-State Actors would ensure that there would be no private sector secondment to the staff and that staff seconded from other non-State actors would go through adequate filters and due diligence. He was therefore confident that full representation on the Committee would not involve any conflict of interest. He would support a resolution on representation on the Programme, Budget and Administration Committee, since that was the appropriate place for staff to express concerns, and would welcome further information from the Secretariat on litigation.

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

The representative of ZAMBIA[1] endorsed the statement by the representative of Thailand. There should be greater transparency in staff matters, with competent staff hired from all regions.

The DIRECTOR (Human Resources Management) assured the Board that everything they had said would be considered carefully. There was constructive dialogue between management and staff associations across the Organization. Management valued the comments, suggestions and proposals made by staff associations, and elicited their comments on planned policy changes and amendments to the Staff Rules. There was also an increasing number of joint initiatives, such as the joint staff-management working group on promoting a respectful workplace, which provided opportunities for dialogue. The Organization was still in the voluntary phase of mobility, so it was not yet a matter of rotating hundreds of positions a year. The three years of the voluntary phase would be used to test whether or not a larger scale of rotation was feasible. The Global Mobility Committee was an advisory body; the ultimate decision on assigning a staff member to a particular position was taken by the Director-General, not the Committee, so there would be no legal issue involved in staff representatives participating as full members rather than observers. She agreed that conflict prevention was crucial to avoiding escalation and formal complaints and appeals. The way forward was to use the Ombudsman, mediators and staff representatives to defuse conflicts. The cases heard by the ILO Administrative Tribunal included many relating to abolition of posts because serious financial constraints had forced the Organization to shed a large number of staff, but the number of appeals to the Tribunal was insignificant compared to the number of staff who had lost their jobs. She reminded the Board that, following the drastic decision to downsize the Organization, it had decided to discontinue the granting of continuing appointments, which had protected staff by allowing them to benefit from enough time to transition within or outside the Organization. In future, more people might appeal against the abolition of their posts because they no longer benefited from that protective regime.

The DIRECTOR-GENERAL said that WHO staff were international civil servants who were there to serve Member States and required a service culture of intellectual capacity, integrity, neutrality, transparency and accountability. The relationship between management and staff associations had improved enormously during her time in office. There had been many appeals regarding the abolition of posts and contractual issues, in part because WHO had been required to suddenly lay off 1000 staff as a result of the 2008 financial crisis. She referred to the fact that 80% of WHO's income was earmarked for specific programmes. She believed it unfair for the Organization and its staff to suffer vulnerability and uncertainty on the basis of income, so, as part of WHO reform, the financing dialogue had been initiated to provide Member States with maximum transparency, in order that they understood that some programmes were at risk and that, when a programme was at risk, staff contracts were too. She had asked Member States to give her some flexibility to move funds between programmes. The financing dialogue and the way in which funds were managed had provided stability to programmes, including some programmes that were critical to the work of the Organization but underfunded. The requested flexibility had been granted, thereby enabling money to be moved between programmes, protecting both the programmes themselves and staff. She encouraged the Board to help the Secretariat continue to reduce the vulnerability of programmes. There were other reasons for the abolition of posts: Member States encouraged the Organization to prioritize some programmes, to abolish others and then retrain staff to manage new priorities. Some people did not take well to retraining and therefore had to be released. She paid tribute to all her staff for their commitment, but reminded them that Member States, and she herself, had high expectations of them. She agreed that prevention was needed; departments and units from which many complaints emanated

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

should be audited as a means of early prevention. The degree of confidentiality imposed could be an obstacle at times to such processes. For example, the Ombudsman was not allowed to give the Director-General early warning of which departments or units were in difficulty.

**The Board took note of the statement by the representative of the staff associations.**

**Matters for information: report on meetings of expert committees and study groups:** Item 9 on the provisional agenda (document EB139/12)

The representative of COLOMBIA[1] expressed appreciation for the report of the Expert Committee on Biological Standardization. The need to update WHO's comparability guidelines nonetheless remained because major scientific, methodological and technical advances that would make it possible to establish the circumstances in which confirmatory human trials were unnecessary still had not been integrated in them. Such exceptions were increasingly incorporated in reference regulations and their incorporation in WHO's biological standards would facilitate implementation of the same by Member States. He recommended that the Expert Committee should draft a technical annex to the biological standards that explicitly established the conditions and circumstances in which it was possible to reduce or dispense with confirmatory human studies for the registration of competing biological medicines. That kind of technical input would be useful to the development of Member States' regulations. It would enable Member States to evaluate the quality and safety of similar or competing biological products and establish ethical standards that minimized patient exposure to studies that were not strictly necessary.

The representative of NEW ZEALAND said there were obvious overlaps between evolving actions on antimicrobial resistance and the decisions by the Joint FAO/WHO Expert Committee on Food Additives. There was scope for the Committee to lead on antimicrobial resistance by being an early adopter of actions to reduce the use of antimicrobials in agriculture and horticulture.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND fully endorsed the remarks made by the representative of New Zealand.

The COORDINATOR (Risk Assessment and Management) thanked New Zealand and the United Kingdom of Great Britain and Northern Ireland for their comments on antimicrobial resistance, which would be included in the scientific advice provided by the Committee for discussion at the next session of the Codex Alimentarius Commission in June and July 2016, when the Secretariat, FAO and WHO would present a paper on the subject, with a view to updating existing guidance and considering whether work in expert committees could be strengthened.

The representative of BRAZIL commented that the overlap of the work of the Joint FAO/WHO Expert Committee on Food Additives on the presence of certain veterinary drug residues in food and the Codex Alimentarius was more apparent than real. It would be wrong to establish any automatic linkages with antimicrobial resistance. The Organization should not inappropriately merge different tracks on issues that were similar, yet followed different priorities and rules and had different objectives. The Codex Alimentarius was linked with certain WTO agreements and was the basis for addressing trade barriers, for example.

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

The CHAIRMAN requested the Secretariat to convey the gratitude of the Board to the experts for their contributions and to follow up on their recommendations as appropriate.

**The Board noted the report.**

## 3. FUTURE SESSIONS OF THE EXECUTIVE BOARD AND THE HEALTH ASSEMBLY: Item 10 of the agenda (document EB139/13)

The DIRECTOR (Governing Bodies and External Relations), introducing the draft provisional agenda for the 140th session of the Board, said that within four weeks of the closure of the current session of the Board, the Director-General would send a note verbale to all Member States together with the draft provisional agenda, following which Member States would have a 12-week period in which to submit comments and proposals. The Director-General would subsequently consult with the the Officers of the Board on any proposals; the note for the record of that discussion would be shared with Member States through the SharePoint site, and the outcome would be included in the annotated provisional agenda. The Director-General and the Officers of the Board would also review the six-year forward-looking planning schedule of expected agenda items, the so-called rolling agenda, in accordance with a decision adopted recently by the Sixty-ninth World Health Assembly, on governance reform.

The CHAIRMAN took it that the Board wished to adopt the two draft decisions contained in document EB139/13.[1]

**It was so decided.**

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND asked whether the rolling agenda would also be made available to Member States.

The representative of NEPAL said that, in the light of the interest expressed by many Member States in continuing consideration of the item on mHealth at the 140th session of the Board, including the proposed development of a draft resolution thereon, he wished to request the inclusion of that item in the draft provisional agenda.

The CHAIRMAN said that the agenda for the 140th session of the Board had already been approved and, therefore, the inclusion of additional items was not possible. However, the issues discussed at the Health Assembly would in turn be discussed by the Board; additional items could therefore be included through that process.

The representative of VIET NAM[2] requested that the dates of the 140th session of the Board should be changed, as the national holiday of Viet Nam, and that of several other countries in the South-East Asia Region, coincided with those dates.

[1] Decision EB139(10) and decision EB139(11).

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

The CHAIRMAN confirmed that, since the item had been closed, it would not be possible to amend the dates of the next session of the Board.

The representative of FIJI[1] sought clarification as to whether the draft provisional agenda for the 140th session of the Board was now closed.

The CHAIRMAN explained that the provisional agenda existed in draft form only; a second, more formal, version would be compiled by the Director-General and sent to Member States for their consideration within four weeks of the closure of the current session. It would take into account the decisions and resolutions of the Health Assembly and the Board.

## 4. CLOSURE OF THE SESSION: Item 11 of the Agenda

**The Board conveyed its best wishes to Ms Cecilia Rose-Oduyemi, Director (Governing Bodies and External Relations), on the occasion of her retirement.**

The DIRECTOR-GENERAL warmly congratulated the Chairman on his efficient and effective approach, which would expedite the work of the Board at its next session. She thanked all participants for their comments; Member States' remarks, recommendations and decisions would be taken on board, and subsequently addressed. She hoped that the new rolling agenda, guided by the Officers of the Board, would lighten the workload of the Board.

After the customary exchange of courtesies, the CHAIRMAN declared the 139th session of the Executive Board closed.

**The meeting rose at 13:05.**

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