



WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD

139TH SESSION

GENEVA, 30 and 31 MAY 2016

**RESOLUTION AND DECISIONS
ANNEX**

**SUMMARY RECORDS
LIST OF PARTICIPANTS**

GENEVA
2016



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2016

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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

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

PREFACE

The 139th session of the Executive Board was held at WHO headquarters, Geneva, on 30 and 31 May 2016.¹

The Sixty-ninth World Health Assembly elected 12 Member States to be entitled to designate a person to serve on the Executive Board² in place of those whose term of office had expired,³ giving the following new composition of the Board:

Designating country	Unexpired term of office⁴	Designating country	Unexpired term of office⁴
Algeria.....	3 years	Kuwait.....	1 year
Bahrain.....	3 years	Liberia.....	1 year
Bhutan.....	3 years	Libya.....	3 years
Burundi.....	3 years	Malta.....	2 years
Canada.....	2 years	Mexico.....	3 years
China.....	1 year	Nepal.....	1 year
Colombia.....	3 years	Netherlands.....	3 years
Congo.....	2 years	New Zealand.....	2 years
Democratic Republic of the Congo.....	1 year	Pakistan.....	2 years
Dominican Republic.....	2 years	Philippines.....	2 years
Eritrea.....	1 year	Russian Federation.....	1 years
Fiji.....	3 years	Sweden.....	2 years
France.....	2 years	Thailand.....	2 years
Gambia.....	1 year	Turkey.....	3 years
Jamaica.....	3 years	United Kingdom of Great Britain and Northern Ireland.....	1 year
Jordan.....	2 years	United States of America.....	1 years
Kazakhstan.....	2 years	Viet Nam.....	3 years

Details regarding members designated by the above Member States can be found in the list of members and other participants.⁵

¹ Decision EB138(12) (2016).

² Decision WHA69(7) (2016).

³ The retiring members had been designated by Albania, Andorra, Argentina, Brazil, Democratic People's Republic of Korea, Egypt, Japan, Namibia, Republic of Korea, Saudi Arabia, South Africa, Suriname (see decision WHA66(7) (2013)).

⁴ At the time of the closure of the Sixty-ninth World Health Assembly.

⁵ See page 61.

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8. Staffing matters: statement by the representative of the WHO staff associations
9. Matters for information: report on meetings of expert committees and study groups
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11. Closure of the session

¹ As adopted by the Board at its first meeting.

LIST OF DOCUMENTS

EB139/1 Rev.1	Agenda ¹
EB139/1 (annotated)	Provisional agenda (annotated)
EB139/2	Report of the Programme, Budget and Administration Committee of the Executive Board
EB139/3	Dementia
EB139/4	Improving access to assistive technology
EB139/5	Development of a new Health Assembly resolution and action plan for prevention of deafness and hearing loss
EB139/5 Add.1	Financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly ²
EB139/6	Health and climate change
EB139/7	International Statistical Classification of Diseases and Related Health Problems: update on the eleventh revision
EB139/8	mHealth: use of mobile wireless technologies for public health
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EB139/10 and EB139/10 Add.1	Committees of the Executive Board: filling of vacancies
EB139/11	Process for the election of the Director-General of the World Health Organization: date of the candidates' forum
EB139/12	Report on meetings of expert committees and study groups
EB139/13	Future sessions of the Executive Board and the Health Assembly, and draft provisional agenda of the 140th session of the Executive Board

¹ See page ix.

² See Annex.

Information document

EB139/INF./1 Statement by the representative of the WHO staff associations

Diverse documents

EB139/DIV./1 Rev.1 List of members and other participants

EB139/DIV./2 Decisions and list of resolutions

EB139/DIV./3 Instructions on using the electronic voting system for the nomination and appointment of the Director-General

EB139/DIV./4 List of documents

COMMITTEES¹

Programme, Budget and Administration Committee²

Dr Rubén Agustín Nieto (Argentina), Ms Zhang Yang (China), Dr Blanchard Mukengeshayi Kupa (Democratic Republic of the Congo), Professor Benoît Vallet (France), Mr Omar Sey (Gambia), Dr Ali Saad Al-Obaidi (Kuwait), Dr Raymond Busuttil (Malta, member ex officio), Mr Ramjanam Chaudhary (Nepal), Dr Jeon Man-bok (Republic of Korea), Dr Abdullah bin Mifreh Assiri (Saudi Arabia), Ms Precious Matsoso (South Africa, member ex officio), Dr Phusit Prakongsai (Thailand), Mrs Kathryn Tyson (United Kingdom of Great Britain and Northern Ireland) and Dr Thomas Frieden (United States of America).

Twenty-fourth meeting, 19 and 20 May 2016:³ Mrs Kathryn Tyson (United Kingdom of Great Britain and Northern Ireland, Chairman), Ms J. Costanzi (Argentina, alternate to Dr Rubén Agustín Nieto), Ms Zhang Yang (China), Professor A. Elira Dokékias (Democratic Republic of the Congo, alternate to Dr Blanchard Mukengeshayi Kupa), Mrs E. Laurin (France, alternate to Professor Benoît Vallet), Mr H. Abulhasan (Kuwait, alternate to Dr Ali Saad Al-Obaidi), Dr Raymond Busuttil (Malta, member ex officio), Dr P. Bahadur Chand (Nepal, alternate to Mr Ramjanam Chaudhary), Dr Jeon Man-bok (Republic of Korea), Dr Abdullah bin Mifreh Assiri (Saudi Arabia), Ms Precious Matsoso (South Africa, member ex officio), Dr Phusit Prakongsai (Thailand, Vice-Chairman) and Ms Ann Blackwood (United States of America, alternate to Dr Thomas Frieden).

¹ Showing current membership and the names of those who attended the meeting to which reference is made.

² Showing the membership as determined by the Executive Board in decision EB137(1) (2015), with changes of representatives for Argentina and Nepal and the replacement of the representative for Andorra by the representative for Malta.

³ See document EBPBAC24/DIV./1.

PART I

RESOLUTION AND DECISIONS

ANNEX

RESOLUTION

EB139.R1 Development of a new Health Assembly resolution and action plan for prevention of deafness and hearing loss

The Executive Board,

Having considered the report on the development of a new Health Assembly resolution and action plan for prevention of deafness and hearing loss,¹

RECOMMENDS to the Seventieth World Health Assembly the adoption of the following resolution:²

The Seventieth World Health Assembly,

Recognizing that 360 million people across the world live with disabling hearing loss, a total that includes 32 million children and nearly 180 million older adults;

Acknowledging that nearly 90% of the people with hearing loss live in low- and middle-income countries, which often lack resources and strategies to address hearing loss;

Concerned by the persistent high prevalence of chronic ear diseases, such as chronic suppurative otitis media, which lead to hearing loss and may cause life-threatening complications;

Acknowledging the significance of work-related, noise-induced hearing loss, in addition to issues related to recreational and environmental noise-induced hearing loss;

Aware that unaddressed hearing loss is linked with cognitive decline and contributes to the burden of depression and dementia, especially in older adults;

Noting the significant impact of ear diseases and hearing loss on the development, ability to communicate, education, livelihood, social well-being and economic independence of individuals, as well as on communities and countries;

Aware that most of the causes of hearing loss are avoidable with preventive strategies; that the interventions available are both successful and cost-effective; but that, despite this, most people with ear diseases and hearing loss do not have access to suitable services;

Recalling resolution WHA48.9 (1995) on prevention of hearing impairment, and resolution WHA58.23 (2005) on disability, including prevention, management and rehabilitation;

¹ Document EB139/5.

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

Recalling also the *World report on disability 2011*, which recommends investment in improved access to health services, rehabilitation and assistive technologies and the WHO global disability action plan 2014–2021,¹ based on the report's recommendations;

Mindful of the Sustainable Development Goals in the 2030 Agenda for Sustainable Development, specifically Goal 3 (Ensure healthy lives and promote well-being for all at all ages) with its target 3.8 on achieving universal health coverage, which implicitly recognizes the need for persons with disabilities to have access to quality health care services, and recognizing that the targets of Goal 4 (Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all) explicitly mention persons with disabilities, and that unaddressed hearing loss greatly hinders their education and academic outcomes;

Appreciating the efforts made by Member States and international partners in recent years to prevent hearing loss, but mindful of the need for further action,

1. URGES Member States, taking into account their national circumstances:
 - (1) to integrate strategies for ear and hearing care within the framework of their primary health care systems, under the umbrella of universal health coverage, by such means as raising awareness at all levels and building political commitment and intersectoral collaboration;
 - (2) to collect high-quality population-based data on ear diseases and hearing loss in order to develop evidence-based strategies and policies;
 - (3) to establish suitable training programmes for the development of human resources in the field of ear and hearing care;
 - (4) to ensure the highest possible coverage of vaccination against rubella, measles, mumps and meningitis, in line with the immunization targets of the global vaccine action plan 2011–2020, and in accordance with national priorities;
 - (5) to develop, implement and monitor screening programmes for early identification of ear diseases, such as chronic suppurative otitis media and hearing loss in high-risk populations, including infants, young children, older adults and people exposed to noise in occupational and recreational settings;
 - (6) to improve access to affordable, cost-effective, high-quality, assistive hearing technologies and products, including hearing aids, cochlear implants and other assistive devices, as part of universal health coverage, taking into account the delivery capacity of health care systems in an equitable and sustainable manner;
 - (7) to develop and implement regulations for the control of noise in occupational settings, at entertainment venues and through personal audio systems, as well as for the control of ototoxic medicines;
 - (8) to improve access to a variety of ways of communicating through promoting alternative methods of communication, such as sign language and captioning;

¹ WHO global disability action plan 2014–2021 is available at http://www.who.int/disabilities/about/action_plan/en/ (accessed 7 December 2016).

(9) to work towards the attainment of Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and Goal 4 (Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all) in the 2030 Agenda for Sustainable Development, with special reference to people with hearing loss;

2. REQUESTS the Director-General:

(1) to prepare a world report on ear and hearing care, based on the best-available scientific evidence;

(2) to develop a toolkit as well as provide the necessary technical support for Member States in collecting data, planning national strategies for ear and hearing care, specifying how prevention of hearing loss can be integrated in other health care programmes, raising awareness, screening for hearing loss and ear diseases, training and provision of assistive technologies;

(3) to intensify collaboration with all stakeholders with the aim of reducing hearing loss due to recreational exposure to noise through the development and promotion of safe-listening standards, screening protocols, software applications to promote safe-listening and information products;

(4) to undertake advocacy through World Hearing Day on 3 March each year, with a different theme every year;

(5) to report on progress in the implementation of the present resolution to the World Health Assembly.¹

(Second meeting, 30 May 2016)

¹ The Executive Board agreed that the long-term reporting requirements of the present resolution should be included in the forward-looking planning schedule of expected agenda items, established by decision WHA69(8) (2016), see the summary record of the Executive Board at its 139th session, second meeting (available in the present volume: document EB139/2016/REC/1).

DECISIONS

EB139(1) Dementia

The Executive Board, having considered the report by the Secretariat on dementia,^{1,2}

(1) noted that the response to the global burden of dementia can be greatly enhanced by a shared commitment among Member States and all other stakeholders to put in place the necessary policies and resources for care of people with dementia, to promote research, to find disease-modifying treatments or cure, and to give adequate priority to action against dementia in national and global political agendas;

(2) decided to request the Director-General to develop with the full participation of Member States and in cooperation with other relevant stakeholders a draft global action plan on the public health response to dementia, with clear goals and targets, for consideration by the Seventieth World Health Assembly, through the Executive Board at its 140th session.

(First meeting, 30 May 2016)

EB139(2) Standing Committee on Nongovernmental Organizations

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 henceforth conduct the review of any non-State actors applying to be in official relations, as well as the review of renewals.

(Third meeting, 31 May 2016)

EB139(3) Membership of the Programme, Budget and Administration Committee

The Executive Board appointed as members of the Programme, Budget and Administration Committee Dr Nelson Antonio Rodríguez Monegro (Dominican Republic), Dr Lyonpo Tandin Wangchuk (Bhutan), Ms Olivia Wigzell (Sweden), Ms Zhang Yang (China), Dr Ali Hyasat (Jordan) and Dr Stewart Jessamine (New Zealand) for a two-year period or until expiry of their membership on the Board, whichever is first, in addition to Dr Mukengeshayi Kupa (Democratic Republic of the Congo), Mr Omar Sey (Gambia), Dr Thomas Frieden (United States of America), Dr Phusit Prakongsai (Thailand), Professor Benoît Vallet (France), and Dr Ali Saad Al-Obaidi (Kuwait), who were already members of the Committee. Dr Raymond Busuttil (Malta), Chairman of the Board, and Ms Faeqa Saeed Alsaleh (Bahrain), Vice-Chairman of the Board, were appointed members ex officio. It was understood that if any of the Committee members were unable to attend, except the two ex-officio members, his or her successor, or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure of the Executive Board, would participate in the work of the Committee.

(Third meeting, 31 May 2016)

¹ Document EB139/3.

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

EB139(4) Membership of the Léon Bernard Foundation Committee

The Executive Board, in accordance with the Statutes of the Léon Bernard Foundation, appointed Ms Veronika Igorevna Skvortsova (Russian Federation) as a member of the Léon Bernard Foundation Committee for the duration of her term of office on the Executive Board, in addition to the Chairman and Vice-Chairmen of the Board, members ex officio. It was understood that if Ms Svortsova was unable to attend, her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure of the Executive Board, would participate in the work of the Committee.

(Third meeting, 31 May 2016)

EB139(5) Membership of the United Arab Emirates Health Foundation Selection Panel

The Executive Board, in accordance with the Statutes of the United Arab Emirates Health Foundation, appointed Dr Faiqa Saeed Al-Saleh (Bahrain) as a member of the United Arab Emirates Health Foundation Selection Panel for the duration of her term of office on the Executive Board, in addition to the Chairman of the Board, member ex officio. It was understood that if Dr Al-Saleh was unable to attend, his successor or the alternate member of the Board designated by the Government concerned, in accordance with Rule 2 of the Rules of Procedure of the Executive Board, would participate in the work of the Panel.

(Third meeting, 31 May 2016)

EB139(6) Membership of the Sasakawa Health Prize Selection Panel

The Executive Board, in accordance with the Statutes of the Sasakawa Health Prize, appointed Dr Nguyen Kim Tien, (Viet Nam) as a member of the Sasakawa Health Prize Selection Panel for the duration of his term of office on the Executive Board, in addition to the Chairman and a representative appointed by the Founder, members ex officio. It was understood that if Dr Kim Tien was unable to attend, his successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure of the Executive Board, would participate in the work of the Panel.

(Third meeting, 31 May 2016)

EB139(7) Membership of the State of Kuwait Health Promotion Foundation Selection Panel

The Executive Board, in accordance with the Statutes of the State of Kuwait Health Promotion Foundation, appointed Dr Ali Hyasat (Jordan) as a member of the Health Promotion Foundation Selection Panel for the duration of his term of office on the Executive Board, in addition to the Chairman and a representative of the Founder, members ex officio. It was understood that if Dr Hyasat was unable to attend, his successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure of the Executive Board, would participate in the work of the Panel.

(Third meeting, 31 May 2016)

EB139(8) Appointment of representatives of the Executive Board to the Seventieth World Health Assembly

The Executive Board, in accordance with paragraph 1 of resolution EB59.R7, appointed its Chairman, Dr Raymond Busuttil (Malta), and its first three Vice-Chairmen, Dr Thomas Frieden (United States of America), Dr Ramjanam Chaudhary (Nepal) and Ms Zhang Yang (China) to represent the Executive Board at the Seventieth World Health Assembly. It was understood that if any of those members were not available for the Health Assembly, the other Vice-Chairman, Mrs Faeqa Saeed Alsaleh (Bahrain), and the Rapporteur, Mr Omar Sey (Gambia), could be asked to represent the Board.

(First meeting, 30 May 2016)

EB139(9) Process for the election of the Director-General of the World Health Organization: date of the candidates' forum

The Executive Board, having considered the report on the process for the election of the Director-General of the World Health Organization,¹ decided that the candidates' forum shall be held starting from Tuesday, 1 November 2016 for a duration that will be further decided by the Officers of the Board depending on the number of candidates.

(Third meeting, 31 May 2016)

EB139(10) Place, date and duration of the 140th session of the Executive Board and the twenty-fifth meeting of the Programme Budget and Administration Committee of the Executive Board

The Executive Board decided that its 140th session should be convened on Monday, 23 January 2017, at WHO headquarters, Geneva, and should close no later than Wednesday, 1 February 2017. The Board further decided that the Programme, Budget and Administration Committee of the Executive Board should hold its twenty-fifth meeting from Wednesday, 18 January, to Friday, 20 January 2017, at WHO headquarters, Geneva.

(Third meeting, 31 May 2016)

EB139(11) Place, date and duration of the Seventieth World Health Assembly and the twenty-sixth meeting of the Programme, Budget and Administration Committee of the Executive Board

The Executive Board decided that the Seventieth World Health Assembly should be held at the Palais des Nations, Geneva, opening on Monday, 22 May 2017, and should close no later than Wednesday, 31 May 2017. The Board further decided that the Programme, Budget and Administration Committee of the Executive Board should hold its twenty-sixth meeting on Thursday, 18 May and Friday, 19 May 2017, at WHO headquarters, Geneva.

(Third meeting, 31 May 2016)

¹ Document EB139/11.

ANNEX

Financial and administrative implications for the Secretariat of resolutions and decisions adopted by the Executive Board

Resolution EB139.R1 Development of a new Health Assembly resolution and action plan for prevention of deafness and hearing loss			
A. Link to the general programme of work and the programme budget			
<p>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.</p> <p>Twelfth General Programme of Work 2014–2019: Impacts: reducing premature mortality from noncommunicable diseases; and preventing death, illness and disability arising from emergencies; outcome: 2.4; and output: 2.4.2.</p>			
<p>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.</p> <p>Not applicable.</p>			
<p>3. What is the proposed timeline for implementation of this resolution?</p> <p>From 2017 to 2021.</p> <p><i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i></p>			
B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	0.100	0.150	0.250
Regional offices	0.300	0.125	0.425
Headquarters	1.000	0.500	1.500
Total	1.400	0.775	2.175
<p>1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)</p> <p>Yes.</p>			
<p>1(b) Financing implications for the budget in the current biennium:</p> <ul style="list-style-type: none"> – How much is financed in the current biennium? US\$ 1.7 million. – What are the gaps? US\$ 0.475 million. – What action is proposed to close these gaps? The gap will be addressed through coordinated resource mobilization efforts, including the financing dialogue, for possible financing by voluntary contributions. 			

2. Next biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	0.20	0.75	0.95
Regional offices	0.60	0.50	1.10
Headquarters	1.50	1.35	2.85
Total	2.30	2.60	4.90

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

- **How much is currently financed in the next biennium?**
US\$ 1.7 million.
- **What are the financing gaps?**
US\$ 3.2 million.
- **What action is proposed to close these gaps?**
The gap will be addressed through coordinated resource mobilization efforts, including the financing dialogue, for possible financing by voluntary contributions.

Decision EB139(1) Dementia			
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 decision will contribute if adopted.			
Twelfth General Programme of Work 2014–2019: output 2.2.2.			
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 decision.			
Not applicable.			
3. What is the proposed timeline for implementation of this decision?			
Over 6 months in the period 2016–2017.			
<i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the decision			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	0	0	0
Regional offices	0	0	0
Headquarters	0.14	0.46	0.6
Total	0.14	0.46	0.6
1(a) Is the estimated budget requirement in respect of implementation of the decision fully included within the current programme budget? (Yes/No)			
Yes.			

<p>1(b) Financing implications for the budget in the current biennium:</p> <ul style="list-style-type: none"> – How much is financed in the current biennium? 0 – What are the gaps? US\$ 0.6 million. – What action is proposed to close these gaps? Through coordinated resource mobilization and voluntary specified funding. 			
<p>2. Next biennium: estimated budgetary requirements, in US\$ million</p>			
Level	Staff	Activities	Total
Country offices	0	0	0
Regional offices	0	0	0
Headquarters	0	0	0
Total	0	0	0
<p>2(a) Financing implications for the budget in the next biennium: in US\$ million</p> <ul style="list-style-type: none"> – How much is currently financed in the next biennium? 0 – What are the financing gaps? 0 – What action is proposed to close these gaps? Not applicable. 			

PART II

SUMMARY RECORDS

LIST OF PARTICIPANTS

SUMMARY RECORDS

FIRST MEETING

Monday, 30 May 2016, at 09:35

Chairman: Ms M.P. MATSOSO (South Africa)

later: Dr R. BUSUTTIL (Malta)

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

The CHAIRMAN said that the Board would proceed to elect its Chairman, Vice-Chairmen and Rapporteur before adopting its agenda. She drew attention to Rule 12 of the Rules of Procedure of the Executive Board, which set out the procedures for electing Officers of the Board. Following the principle of rotation among WHO regions, Dr Raymond Busuttil (Malta) had been nominated for the office of Chairman of the Executive Board.

Dr Raymond Busuttil (Malta) was elected Chairman.

Dr Busuttil took the Chair.

The CHAIRMAN thanked the Board for electing him and paid tribute to his predecessor. He drew attention to Rule 12 of the Rules of Procedure of the Executive Board, which set out the procedures for electing Officers of the Board. Following the principle of geographical rotation, and on the basis of consultations in the respective regions, the following nominations had been made for the four Vice-Chairmen: Ms Faeqa Saeed Alsaleh (Bahrain), Dr Ramjanam Chaudhary (Nepal), Dr Thomas Frieden (United States of America) and Ms Zhang Yang (China).

Ms Faeqa Saeed Alsaleh (Bahrain), Dr Ramjanam Chaudhary (Nepal), Dr Thomas Frieden (United States of America) and Ms Zhang Yang (China) were elected Vice-Chairmen.

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

It was determined by lot that the Vice-Chairmen would serve in the following order: Mr Frieden (United States of America), Dr Chaudhary (Nepal), Ms Zhang Yang (China), Ms Alsaleh (Bahrain).

The CHAIRMAN said that, pursuant to Rule 12 of the Rules of Procedure of the Executive Board and in accordance with the principle of rotation among geographical regions, Mr Omar Sey (Gambia) had been nominated Rapporteur.

Mr Sey was elected Rapporteur.

2. **OPENING OF THE SESSION:** Item 2 of the provisional agenda

The CHAIRMAN declared open the 139th session of the Executive Board.

The representative of COLOMBIA, speaking in her capacity as Chair of the informal open-ended working group of Member States, reported on its work. There had been no consensus on the inclusion of an agenda item addressing the health and well-being of lesbian, gay, bisexual and transgender people. An interactive dialogue had been held on 26 February 2016 to facilitate a constructive exchange of national experiences, and tackle the priority health care needs of the whole population, leaving no one behind and bearing in mind that inclusion was a principle for the health sector. She had prepared a summary of proceedings that was not indicative of any consensus, actions or way forward. It had been circulated to focal points on 24 March 2016. She had received comments from some Member States and regions that focused on certain aspects in the summary in order to clarify national and regional positions. She highlighted the importance of dialogue and listening to each other as a foundation on which to build.

The representative of the UNITED STATES OF AMERICA said that the results of the dialogue indicated a way forward for Member States, since there had been strong recognition that health systems should be structured and staff trained to ensure that no one was left behind, whatever challenges a specific population faced, such as age, sex, ethnicity, migrant status, sexual orientation, gender identity or disability. Another point of potential discussion in the future was improving health information, including the benefits and challenges of disaggregating data for underserved populations, for example.

The representative of the NETHERLANDS, speaking on behalf of the European Union and its Member States and of Norway, said that enjoyment of the highest attainable standard of physical and mental health, which could not be achieved without access to health services, was a human right recognized in international treaties ratified by most of the Member States in the room. He appreciated the candour of Member States at the dialogue and their willingness to share national experiences, which described the stigmatization, discrimination and therefore barriers faced by different populations. The European Union and its Member States remained convinced that WHO needed to continue to address all barriers and help Member States overcome stigmatization in the health system and to ensure that health services truly left no one behind.

The representative of THAILAND shared the concerns expressed by the previous two speakers. Common ground should be found in order for discussions to take place concerning population groups with specific health problems and how such health problems affect the wider population. There were sensitivities in some countries to certain terminology; he expressed the hope that terminology acceptable to everyone could be found in order to enable more work to be done on the issue.

The representative of URUGUAY¹ said that an undesirable precedent had been set by the fact that the subject under discussion had not been included as an agenda item. Despite many efforts since 2013, Member States had been unable to have a frank exchange about access to health by lesbian, gay, bisexual and transgender people, which was a clear illustration of the discrimination and stigmatization faced by those population groups. Such a situation ran counter to the commitment to guarantee the right of everyone to enjoy the highest attainable standard of physical and mental health. For the moment, a debate among Member States was not possible, thus the Secretariat should

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

strengthen its technical work and continue to draw up policy options and proposals for measures that would guide health systems on the basis of scientific evidence and best practices.

The representative of ALGERIA, speaking on behalf of the African Region, noted the summary by the Chair of the informal open-ended working group, which had highlighted the lack of consensus. The African Region fully supported the principle of non-discrimination in the provision of health care but emphasized that the possible inclusion of an item on the Board's agenda concerning the health and well-being of lesbian, gay, bisexual and transgender populations remained controversial, in particular because contexts differed in different countries. Until there was consensus in that regard, it could not be included and dialogue should continue. The summary that had been presented to the informal open-ended working group was the sole responsibility of the Chair.

The representative of ARGENTINA¹ stressed the transparency and inclusiveness of the procedure. The meeting had been positive, since it had offered an opportunity to hear the different views. Universal health coverage was a priority for Argentina and he therefore supported any initiative to combat stigmatization and discrimination.

The representative of PANAMA¹ expressed regret that the subject was not an agenda item for discussion. The lack of information about the health of lesbian, gay, bisexual and transgender people concealed their health status and delayed action that could be taken to combat stigmatization, improve health and save lives. The Organization should strengthen technical cooperation to support countries in compiling and analysing data on the health needs of those population groups, the obstacles they faced in accessing health care and the effect of stigmatization on their health and well-being. Such measures should help promote equal access to health services.

The representative of AUSTRALIA¹ voiced his disappointment at the fact that Member States could not agree to discuss the health challenges facing lesbian, gay, bisexual and transgender people. There was clear evidence that those population groups suffered high rates of violence, mental health conditions and HIV, and were denied appropriate health care services due to stigmatization and discrimination or because their status was misclassified as a disease. The health challenges of other populations had been discussed in the governing bodies. His country was committed to working with other Member States to achieve universal health coverage for all people, regardless of sexual orientation or gender identity, and to advocate the principle set out in the WHO Constitution: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." He requested that the Secretariat should continue its technical work on the health needs of lesbian, gay, bisexual and transgender people.

The representative of BRAZIL¹ emphasized the importance of supporting public policies geared towards universal health coverage and access to medicines, health services and treatment. The Secretariat should continue its evidence-based technical activities that took into account the public health perspective, with a view to moving the issue forward.

The representative of CANADA stressed the importance of dialogue on the issue and on continued technical support from the Organization. The higher rates of anxiety, stress and suicide ideation caused by homophobia, biphobia and transphobia created barriers to accessing health services. More data were needed to understand the health issues of all vulnerable groups and how to overcome those barriers. Although her country would take steps to that end, the issue was global.

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

The representative of MEXICO expressed regret that the issue had not been included on the Board's agenda and stressed the need for continued dialogue on the matter within the Board. There should be no discrimination in the provision of health care, and his country was taking legislative and practical steps to ensure that was so.

The representative of the RUSSIAN FEDERATION reiterated that the provision of health services without discrimination should be ensured in accordance with the WHO Constitution. Before continuing dialogue on the subject or including the issue on the Board's agenda, which would require resources, the Secretariat should be requested to gather data on cases where those particular population groups were denied full access to health care.

The representative of EGYPT¹ urged Member States to refrain from making substantive comments on the subject as if it had been included on the Board's agenda. As noted in the balanced summary presented by the Chair of the informal open-ended working group, there was no consensus among Member States to include such an agenda item.

3. ADOPTION OF THE AGENDA: Item 3 of the provisional agenda (documents EB139/1 Rev.1 and EB139/1(annotated))

The CHAIRMAN took it that the Board agreed to adopt the provisional agenda contained in document EB139/1.

The agenda was adopted.

The CHAIRMAN proposed that the Board should take up its agenda items in numerical order.

It was so decided.

4. OUTCOME OF THE SIXTY-NINTH WORLD HEALTH ASSEMBLY: Item 4 of the agenda

The representative of ALGERIA, speaking on behalf of the 47 Member States of the African Region, expressed appreciation for the conduct of the Health Assembly, the pertinent remarks made by the Director-General and the relevance of the Health Assembly's general discussion. His region had been able to share its concerns and the challenges it faced, particularly with regard to the fragility of health systems in emergency situations. The African Region had played an active and constructive role in the formal and informal discussions held in the search for consensus on sensitive issues. He drew attention to the need for the Organization to continue its governance reforms, to work with non-State actors and to ensure that the process of electing its next Director-General was transparent and equitable. Decisions were needed on the role of WHO in emergency situations and on the International Health Regulations (2005).² He emphasized the importance of implementing the Global Strategy for

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

² Document A69/20.

Women's, Children's and Adolescents' Health¹ and the need to continue global efforts to support and strengthen health systems. His region had worked hard to ensure the adoption of decisions and resolutions on those issues. Though many challenges remained, significant progress had been made in the areas of health emergency management, governance reform and collaboration with non-State actors. It was to be hoped that future Health Assemblies would see their workload reduced to ensure that sufficient time could be devoted to all agenda items. Timely publication of documentation in all languages would help delegations to prepare for the Health Assembly.

The representative of CHINA said that, while progress had been made in reforming the Organization's governance, time constraints during the Health Assembly had made the work of some drafting groups less transparent than was desirable. Moreover, some key issues had not been discussed fully. Her country had hoped to see an agenda item on insect vector control, for instance. Member States should be more focused in deciding on the agendas of the Executive Board and the World Health Assembly.

The representative of COLOMBIA noted that it was interesting to see how many topics of importance to global health were discussed by the Organization's governing bodies. The Organization had a fundamental role to play in guiding Member States as they tackled common challenges. The Sixty-ninth World Health Assembly had adopted resolutions and decisions in a number of key areas, such as HIV, tuberculosis, hepatitis, ageing and nutrition. He particularly welcomed its commitment to ending the inappropriate promotion of foods for infants and young children and tackling childhood obesity. It was important for the Organization to preserve its technical and scientific nature and for the agendas of its governing bodies to be well balanced.

The representative of the PHILIPPINES noted that, despite its very tight schedule, the Health Assembly had adopted a number of important resolutions, most significantly on the Framework of Engagement with Non-State Actors.² Echoing concerns that there were too many items on the Health Assembly's agenda, she urged the Executive Board to prioritize better so as to ensure that the quality of discussion was not compromised by the quantity of issues.

The representative of SWEDEN pointed out that the Health Assembly's overcrowded agenda not only reflected a lack of ability to prioritize and use the general programme of work and the programme budget as central steering tools, but also posed a democratic problem: smaller delegations, in particular, were unable to participate equally. It was disappointing that the reform process had not yielded agreement on specific measures to tackle those problems. Member States and the Secretariat should work together to improve the situation. She welcomed the important decisions taken by the Health Assembly, particularly on reforming the Organization's work in health emergency management, the Framework of Engagement with Non-State Actors and the Global Plan of Action on Violence.

The representative of TURKEY emphasized the importance of the Health Assembly's work, particularly the decisions it had taken on the Framework of Engagement with Non-State Actors, healthy ageing, health emergency management and the Global Plan of Action on Violence.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND expressed strong support for the comments made by the representatives of the Philippines

¹ Document A69/16.

² Resolution WHA69.10 (2016).

and Sweden. The Board must play a role in better prioritizing the use of Secretariat resources and in governance reform as a whole.

The representative of THAILAND noted that, while the increasing number of items on the governing bodies' agendas reflected Member States' interest in the work of the Organization, deciding how to merge various items was a challenge. He suggested that the work of the Health Assembly could be improved by reducing the length of time allowed to each speaker, giving notice in advance if agenda items were to be merged, and better management of intersessional activities.

The representative of NEW ZEALAND said that the open-ended agendas and work programmes of the Health Assembly were unsustainable in the current financial climate. The Board, in its role as a proxy for Member States, had the opportunity to review and prioritize the governance of the Health Assembly and the expertise to consider the strategic direction that the Organization would take in coming bienniums. Expressing support for the comments made by the representatives of Sweden, the United Kingdom of Great Britain and Northern Ireland, the Philippines and others, he suggested a joint meeting of the Board and Secretariat on WHO strategy and operational prioritization as part of the Organization's wider reform agenda.

The representative of LIBERIA said that focusing on agreeing and presenting strong regional positions and reducing the time devoted to reports on activities in individual countries would make the work of the Health Assembly more efficient. Discussion should be limited to technical issues arising from reports submitted and presentations made. Dispensing with some of the formal greetings employed might also save time.

The representative of CANADA echoed the comments made by previous speakers.

The representative of FIJI explained that countries with small delegations, such as his own, had experienced great difficulties in coping with the extensive agenda. Setting priorities would enable full participation of smaller States and he encouraged Member States to move in that direction.

The representative of VIET NAM, highlighting key outcomes of the Sixty-ninth World Health Assembly, said that Member States and WHO should endeavour to improve agenda setting, further limit the time allocated to speakers and avoid repetitive statements.

The representative of MEXICO noted that one key outcome of the Health Assembly was its decision regarding a forward-looking schedule for the agendas of the Executive Board and the Health Assembly. The valuable comments from Member States illustrated the crucial importance of that decision to improving the work of WHO's governing bodies.

The representative of the DEMOCRATIC REPUBLIC OF THE CONGO remarked that the implementation of the Millennium Development Goals had shown that the greatest enemy was time. When it came to the Sustainable Development Goals, implementation should be prioritized and the mobilization of resources through synergies and cooperation was crucial.

The DIRECTOR-GENERAL, thanking Members for their comments, noted that concern about the scale of the Health Assembly's agenda was not new. An agenda of 76 items undermined inclusiveness, since small delegations lacked the capacity to participate in all relevant discussions. She encouraged Member States, who were responsible for setting the agenda, to exercise discipline and work towards more inclusive agenda management.

The CHAIRMAN said that the Officers of the Board would take up the issue of agenda management and prepare relevant proposals for consideration by the Executive Board at its 140th session.

5. REPORT OF THE PROGRAMME, BUDGET AND ADMINISTRATION COMMITTEE OF THE EXECUTIVE BOARD: Item 5 of the agenda (document EB139/2)

The Chairman of the Programme, Budget and Administration Committee of the Executive Board, said that the Committee had considered the Secretariat's annual report on evaluation and noted with appreciation the measures taken in that regard. The Committee had requested that the Secretariat should prioritize activities under the Evaluation Workplan 2016–2017 and present the prioritized list at the Committee's twenty-fifth meeting, and provide information on the progress made on indicators for the reform dashboard in the next evaluation report. Lessons learned from corporate evaluations should inform regional committee discussions on the topic.

The Committee had considered the annual report of the Independent Oversight Advisory Committee. Member States had shared the Advisory Committee's concern regarding open audit recommendations and had requested that the Secretariat should establish a standardized process of escalation; improve institutional learning; extend the sharing of evaluations; continue to strengthen internal controls; and ensure zero tolerance of wrongdoing. Some Member States had reiterated their concerns about direct financial cooperation agreements and had requested that the issue should be given priority. Regional Directors had briefed the Committee on initiatives undertaken in their respective regions to strengthen internal controls and improve compliance. It had been noted that the Directors of Administration and Finance were facilitating institutional learning on matters related to oversight.

With reference to the report on external and internal audit recommendations: progress on implementation, the Committee had urged the Secretariat to prioritize the implementation of audit recommendations, and to undertake a process of institutional learning through a review of audit recommendations that focused on recurring problems.

The Committee had further considered the Reports of the Joint Inspection Unit. One Member State had welcomed recommendation 3 relating to procurement. With regard to real estate issues, the Secretariat had informed the Committee that the Geneva Working Group on Buildings and Renovations had not issued any reports, but that it would endeavour to obtain information on identified best practices, in order to share them with Member States. The Secretariat had also informed the Committee that the draft long-term agreement policy and related procedures would be ready by the third quarter of 2016.

Based on her own experience, extending the tenure of the Chairman of the Committee to two terms would be highly beneficial. Furthermore, given the specific nature of the Committee's work, the members assigned to it must possess the necessary expertise. Timely availability of documents, even in draft form, would improve the Committee's work. Given the nature of issues discussed, it might also be useful to consider extending the time limit for speakers to four minutes. It seemed unproductive to interrupt speakers that made valuable, detailed contributions for the sake of a time limit.

The DIRECTOR-GENERAL agreed that it was important to ensure that members of the Programme, Budget and Administration Committee were experts in financial management, administration and risk management, rather than in technical health issues. The suggestions made by the outgoing Chairman of the Committee should be considered closely. Member States had made tremendous progress in improving WHO management and governance and should keep up the good work.

The representative of TURKEY drew attention to the Committee's outstanding work.

The representative of the CONGO, speaking on behalf of the Member States of the African Region, said that he welcomed the inclusion of recommendations by the Executive Board in the Member State consultative process on governance reform. The Director-General's efforts to implement the financing dialogue and the progress made in regard to the evaluation policy were also praiseworthy. Welcoming the report of the Independent Oversight and Advisory Committee, he emphasized the need to minimize irregularities and reiterated some countries' concern over certain direct financial cooperation agreements. Retired and current WHO staff must have access to equitable health coverage. The biennial Evaluation Workplan for 2016–2017 should be strengthened. He took note of the report on real estate. Work undertaken to align WHO's regulatory framework with the International Civil Service Commission's recommendations, including amendments to the Staff Rules, should be commended. It was encouraging that the draft long-term agreement policy and related procedures on procurement would be ready by the third quarter of 2016.

The representative of SWEDEN noted that the twenty-fourth meeting of the Programme, Budget and Administration Committee had been somewhat unusual. Non-members had participated more actively than members, some of whom had been absent altogether. While efforts had been made to improve gender equality in human resource management, measures such as flexible working hours and working from home were needed to tackle the root causes of gender inequality. Her delegation looked forward to contributing to those discussions during its forthcoming membership of the Committee.

The representative of THAILAND said that ambitious plans often faltered at the implementation stage. Implementation was hard and evaluation could be a sobering experience. It was therefore crucial that evaluation should be firmly embedded during the planning stage of global strategies and action plans.

The representative of CANADA enquired as to whether Member States were expected to take a decision on tenure of the Chairman of the Programme, Budget and Administration Committee prior to the Committee's twenty-fifth meeting. It would be useful for the Secretariat to brief Member States on the expected skills of Committee members.

The DIRECTOR-GENERAL said that Chairmen of the Programme, Budget and Administration Committee had served longer terms in the past in certain circumstances, for example, when the country that held the chairmanship had voluntarily allowed the incumbent to remain as Chairman. Should Member States decide that two-year tenure should become standard procedure, the Secretariat stood ready to implement that decision. She would also discuss requirements for Committee membership with the regional directors.

The Executive Board noted the report.

6. TECHNICAL AND HEALTH MATTERS: Item 6 of the agenda

Dementia: Item 6.1 of the agenda (document EB139/3)

The CHAIRMAN drew attention to a draft decision proposed by the delegations of Austria, Canada, Denmark, Dominican Republic, Ethiopia, Finland, Germany, Japan, the Republic of Korea,

Luxembourg, Malta, Monaco, the Netherlands, Panama, Switzerland, the United Kingdom of Great Britain and Northern Ireland, the United States of America, Uruguay and Zambia, which read:

The Executive Board, having considered the report by the Secretariat on Dementia:¹

(1) noted that the response to the global burden of dementia can be greatly enhanced by a shared commitment among Member States and all other stakeholders to put in place the necessary policies and resources for care of people with dementia, to promote research, to find disease-modifying treatments or cure, and to give adequate priority to action against dementia in national and global political agendas;

(2) decided to request the Director-General to develop with the full participation of Member States and in cooperation with other relevant stakeholders a Draft Global Action Plan on public health response to Dementia, for consideration by the Seventieth World Health Assembly, through the 140th session of the Executive Board.

The financial and administrative implications for the Secretariat were:

Resolution: Dementia			
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.			
General Programme of Work: output 2.2.2.			
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?			
Over 6 months in the period 2016–2017.			
<i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	0	0	0
Regional offices	0	0	0
Headquarters	0.14	0.46	0.6
Total	0.14	0.46	0.6

¹ Document EB139/3.

<p>1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)</p> <p>Yes.</p>			
<p>1(b) Financing implications for the budget in the current biennium:</p> <ul style="list-style-type: none"> – How much is financed in the current biennium? 0 – What are the gaps? US\$ 0.6 million. – What action is proposed to close these gaps? Through coordinated resource mobilization and voluntary specified funding. 			
<p>2. Next biennium: estimated budgetary requirements, in US\$ million</p>			
Level	Staff	Activities	Total
Country offices	0	0	0
Regional offices	0	0	0
Headquarters	0	0	0
Total	0	0	0
<p>2(a) Financing implications for the budget in the next biennium: in US\$ million</p> <ul style="list-style-type: none"> – How much is currently financed in the next biennium? 0 – What are the financing gaps? 0 – What action is proposed to close these gaps? Not applicable. 			

The representative of the DOMINICAN REPUBLIC highlighted the importance of drawing attention to the medical, social, economic and human costs of dementia. The statistics were alarming: dementia was already among the leading causes of disability and death in older people and was projected to grow exponentially in the coming years as a result of the global increase in life expectancy. Furthermore, in low- and middle-income countries, some 80% of mental health patients were not treated, and even in high-income countries the treatment ratio was comparatively low. Urgent action was needed to develop broad, public health-based responses to improve the lives of dementia patients, carers and their families. Governments needed to develop special plans and policies for the prevention, diagnosis and treatment of dementia, or incorporate those elements into existing mental health programmes for older people. The draft decision requested that the Director-General should prepare a global action plan on the health response to dementia, to be submitted to the Seventieth World Health Assembly in order to give dementia patients the attention they deserved.

The representative of JAMAICA said that significant research on dementia had been undertaken in his country, which would like to provide regional leadership in the Caribbean Community to launch a healthy ageing initiative. Dementia should be addressed at the Seventieth World Health Assembly.

The representative of the RUSSIAN FEDERATION expressed support for the draft decision, which her country would like to cosponsor. As life expectancy increased, quality of life was crucial. More research on geriatrics and gerontology, including on psychological health, was crucial to

prevent, diagnose and treat illnesses associated with old age and ensure better medical and social support for older people.

The representative of the NETHERLANDS, speaking on behalf of the European Union and its Member States, said that he recognized WHO's leadership role in addressing dementia at all levels and welcomed the establishment of a global dementia observatory. Concerted action and unified responses were needed to overcome the global challenges posed by dementia. Key issues included raising awareness of dementia, facilitating cross-sectoral and sustained involvement from all stakeholders and promoting the needs of families and caregivers to ensure their physical and mental well-being. He supported the draft decision.

The representative of the UNITED STATES OF AMERICA said that he supported the statement by the representative of the Dominican Republic. Isolation was one of the most difficult aspects of dementia and collective attention to the issue was therefore important to all persons affected by the disease. It was unfortunate that no link had been established between health interventions and a reduced risk for dementia later in life. The Organization's strategies aligned with his country's approach to dementia. He supported the draft decision.

The representative of BAHRAIN, speaking on behalf of the Member States of the Eastern Mediterranean Region, noted that a significant increase in his region of people affected by dementia was linked to the use of tobacco products and lack of exercise. Given the rising number of people living with dementia who did not receive proper care, the issue should be a priority for social and health care services. Awareness should be raised of the impact of dementia and the magnitude of the problem. Measures to improve health services should be in line with, but not limited to, the strategies recommended in the Secretariat's report and should build on existing strategies on ageing and noncommunicable diseases.

The representative of KUWAIT urged greater global efforts to address the burden of dementia and the challenges it posed to health systems. Key issues included diagnosis and support for people living with dementia, proper surveillance of the disease and increased awareness to reduce stigma. Member States would need support from WHO, international partners and non-State actors to implement the strategies to strengthen health services recommended in the report. A global strategy could serve as a road map for all Member States to effectively address dementia.

The representative of KAZAKHSTAN said that the awareness-raising element of the Secretariat's recommended strategies should be strengthened. The majority of people with dementia lived in low- and lower-middle-income countries, which would struggle to effectively address dementia and follow the Secretariat's recommendations, due to a lack of resources. Innovative and inexpensive recommendations were needed, alongside effective and reasonably priced generic drugs. Greater emphasis should be placed on building a relationship with the pharmaceutical industry to further research in that regard. He supported the draft decision.

The representative of THAILAND stated that he would like to cosponsor the draft decision. He emphasized the importance of dementia prevention and surveillance at the community level and the need to strengthen Member States' primary health care and long-term care services as part of universal health coverage and in order to tackle the symptoms and conditions associated with dementia. He proposed that paragraph two of the draft decision should be amended by replacing the phrase "draft global action plan on public health response to dementia" with the words "draft global strategy and plan of action on public health response to dementia with clear goals and targets".

The representative of CANADA said that cooperation was needed at all levels of government and with other sectors to successfully address the public health challenge presented by dementia. Her

Government was actively participating in global efforts on effective dementia treatment and prevention. She supported the Secretariat's recommended strategies to coordinate global action and research. As a cosponsor of the draft decision, she encouraged the Board to support that draft decision, which would complement and reinforce the Global Strategy and Action Plan on Ageing and Health.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND said that dementia was a major challenge linked to ageing, lifestyle factors and noncommunicable disease. Her Government had led global activity to address dementia; the First Ministerial Global Dementia Conference in 2015 had paved the way for wider activity. More global activity was needed, however, with particular emphasis on dementia prevention and improved care of people with dementia.

The representative of BHUTAN, speaking on behalf of the Member States of the South-East Asia Region, noted the importance of timely intervention, in light of the costs associated with dementia and the fact that 60% of people with dementia lived in low- and middle-income countries. Dementia had not been considered a priority for public health in his region, which had led to a lack of awareness, late diagnoses and inadequate care. The global dementia observatory should be developed quickly, since it would allow Member States to formulate evidence-based policies and plans. A strategic action plan on dementia should be drafted that focused on prevention. He supported the draft decision.

The representative of SWEDEN expressed support for the development of a draft global action plan for consideration at the Seventieth World Health Assembly. Her country wished to cosponsor the draft decision.

The representative of MALTA said that the Secretariat's report provided a good starting-point to tackle dementia globally. A coordinated and systematic global response would mitigate the impact of dementia, particularly in low- and middle-income countries that were unable to adequately respond to its many challenges. Dementia was not a direct consequence of ageing, and given available preventive measures, Member States should invest in public health strategies to, inter alia, increase awareness, enable early diagnosis and intervention and provide dementia-friendly care. Depression in people with dementia and their informal carers should be identified and treated; a multisectoral approach that included nongovernmental and patient advocacy organizations and informal carers was critical. The Organization should create a platform for countries to exchange best practices and information, support workforce capacity-building and the development of integrated community-based services, and should provide technical expertise to help countries develop and evaluate national policies and strategies.

The representative of COLOMBIA expressed its appreciation for the Secretariat's plans to establish a global dementia observatory. The Organization should strengthen its global leadership role in addressing dementia and help countries develop national plans. His Government wished to cosponsor the draft decision, which should be approved at the 140th session of the Executive Board, in order that it could be quickly adopted and implemented by regional offices.

The representative of CHINA agreed with the Secretariat's recommended strategies and called for more discussion of the draft decision. Global progress on dementia prevention and treatment was uneven due to the varying availability of financial and technical resources. Differences in social and economic development among Member States should be taken into consideration when developing measures and policies. The Organization should set up a platform for countries to exchange information and best practices.

The representative of MEXICO said that dementia prevention, including the mitigation of risk factors, should be based on existing data. He highlighted some of the strategies in the report, such as making dementia a public health priority and promoting international and national measures based on evidence, equity, inclusion and integration. He supported the development of a draft global action plan on public health response to dementia and wished to add his country as a cosponsor of the draft decision.

The representative of ALGERIA, speaking on behalf of the Member States of the African Region, said that the draft decision contained no specific reference to preventive measures, which were all the more important given that affordable pharmacological treatments for dementia were yet to be found. In that light, he suggested an amendment to the first paragraph of the draft decision, whereby the words “to implement prevention policies” should be inserted after the word “resources”.

The representative of the PHILIPPINES said that despite the development and implementation of models, strategies and interventions, the response to dementia had failed to meet expectations. In drawing up strategic guidance, it was important to take into account resource requirements to ensure that recommendations could be implemented, and to consider ways of building on existing strategies. Her country wished to cosponsor the draft decision.

The representative of the CONGO said that, as life expectancy and living conditions improved in the African Region, particularly in his country, dementia was becoming an increasing problem. The knowledge gap on dementia was reflected in stigmatization and instances of violence. Strategies to tackle dementia should be included in national and regional plans to combat noncommunicable diseases, ageing and violence. The Organization should assist Member States in taking a multisectoral approach to prevention and combating stigmatization, drug abuse and communicable diseases that had an impact on dementia. He supported the amendment to the draft decision proposed by the representative of Algeria and highlighted the need to develop affordable medicines.

The representative of TURKEY observed that dementia could be seen as an indicator of success for health systems. The response to the disease, however, was inadequate due to a lack of prioritization, human and financial resources and investment in research and development. The draft global action plan should position dementia as a global public health priority, intensify collaboration with G7, G20, OECD and Member States, develop guidelines including best practices with a gender-sensitive approach, align current and future resolutions to address health workforce and integrated care gaps, and mobilize financial support and technical expertise for the development of effective treatments. His Government supported and wished to cosponsor the draft decision.

The representative of VIET NAM expressed support for the Secretariat’s report. She recommended a number of strategies to deal with dementia in developing countries, namely through strengthening health systems – in particular primary health care – for the early detection of signs of dementia; improving care for people affected by dementia and their families; and creating better links between hospitals, specialists, community groups, families, carers and primary health care networks.

The representative of SWITZERLAND¹ endorsed the statement by the Dominican Republic and called for urgent joint action with WHO on dementia. Given that no pharmaceutical treatments for dementia had yet been identified, the main treatment was providing comfort to those suffering from the disease. The second treatment was political will and action. There was no time to be lost and she called on the Executive Board to adopt the draft decision.

¹ Participation by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of MONACO¹ said that the Monegasque Association for Research on Alzheimer's Disease had published a report on dementia and its consequences, which would be made available to the Executive Board. Each Member State should be supported by WHO to introduce policies that addressed dementia. She supported the draft decision.

The representative of GERMANY¹ said that research was key to finding a cure for dementia and Germany participated in the European Union Joint Programme Initiative – Neurodegenerative Disease Research. She stressed the importance of exchanging good practices and recognized the global leadership role of WHO in that regard. She supported the adoption of the draft decision.

The representative of JAPAN¹ highlighted the importance of approaching the issue of dementia from the perspective of society and communities, rather than only that of the health sector. His country had taken a cross-sectoral approach through a single national dementia strategy endorsed by 12 ministries and was ready to share its experience with other Member States. In that light, he called on the Secretariat to provide further technical guidance and support for Member States wishing to develop their own strategies and action plans. He supported the draft decision.

The representative of URUGUAY¹ welcomed the Secretariat's report and expressed support for the recommended strategies contained therein. She highlighted the need for an inter-institutional approach to dementia, given that its impact was not limited to the health sector. She urged the Executive Board to adopt the draft decision.

The representative of ITALY¹ said that his country wished to cosponsor the draft decision, with a view to its adoption at the Seventieth World Health Assembly.

The representative of SOUTH AFRICA¹ said that, although overall life expectancy in sub-Saharan Africa was lower than in developed countries, the number of people aged 60 and over was projected to rise. She welcomed the Secretariat's report and looked forward to working with WHO to develop and strengthen her country's national programmes on noncommunicable diseases and mental health, with a view to the management and prevention of dementia.

The representative of SLOVAKIA¹ agreed that there was no time to lose. Member States should follow the example of countries that had adopted national programmes to combat dementia, its causes and consequences. She endorsed the strategies outlined in the report, highlighting the role of WHO in coordinating the transfer of knowledge and experience. Her country wished to cosponsor the draft decision.

The representative of BANGLADESH¹ said that, given that dementia was not yet a national priority in most countries, he supported the draft decision with the amendment proposed by the representative of Thailand.

The representative of the REPUBLIC OF KOREA¹ said that she supported the statement given by the representative of Switzerland. The high prevalence of dementia among the elderly population of the Republic of Korea had prompted a concerted effort from the Government to combat the disease. Prevention and management of risk factors were essential to that effort. She hoped that the issue would be addressed at the Seventieth World Health Assembly to enable countries to share their experiences.

¹ Participation by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of INDIA¹ expressed concern at the number of people in the world suffering from dementia and the large proportion of those living in low- and middle-income countries. He presented a number of measures taken in India to secure the rights of the elderly and endorsed the Secretariat's recommendations. A major barrier in the treatment of dementia was that many people saw it as a normal part of ageing and associated it with a significant physical, mental and financial burden on carers. Efforts to close the treatment gap for dementia were hampered by low levels of awareness and low human resource capacity. The situation called for a community outreach programme on dementia as part of the primary health care system. The possibility of replacing psychiatrists with general practitioners trained in dementia care should also be examined.

The representative of ZAMBIA¹ said that, in view of the increasing prevalence of the disease, sustained efforts were needed to manage dementia, in particular to raise awareness of it among the general population and health workers. He called for the inclusion of preventive policies in planned activities and supported the draft decision as amended by the representative of Algeria. He would welcome collaboration and technical support from WHO and Member States to tackle the challenges of dementia.

(For continuation of the discussion, see the summary record of the second meeting, section 1.)

The meeting rose at 12:30.

¹ Participation by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

SECOND MEETING

Monday, 30 May 2016, at 14:35

Chairman: Dr R. BUSUTTIL (Malta)

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

Dementia: Item 6.1 of the agenda (document EB139/3) (continued)

The representative of PANAMA¹ said that in developing the draft global action plan on the public health response to dementia, the Secretariat should pay particular attention to palliative care.

The representative of PORTUGAL¹ said that his country remained firmly committed to upholding the protection and promotion of the human rights of persons with mental disorders and psychosocial disabilities. He therefore expressed strong support for the preparation of a global action plan on dementia and said that his country wished to be added to the list of sponsors of the draft decision.

The representative of AUSTRALIA¹ welcomed the report and said that her country wished to be added as a sponsor of the draft decision.

The representative of SAUDI ARABIA¹ said that the draft global strategy and plan of action should better reflect the role of the family as the primary caregiver for patients with dementia. Governments should support families dealing with the dementia burden.

The representative of ALZHEIMER'S DISEASE INTERNATIONAL, speaking at the invitation of the CHAIRMAN, said that dementia was a cross-cutting issue with huge personal, social and economic consequences. Given the need for urgent action, the Board should develop a rights-based, patient-focused action plan on dementia that took into account the burden faced by caregivers and family members for consideration at the Seventieth the World Health Assembly.

The representative of the INTERNATIONAL ASSOCIATION FOR HOSPICE AND PALLIATIVE CARE INC., speaking at the invitation of the CHAIRMAN, said that palliative care should be included in the draft global action plan on the public health response to dementia. She highlighted the importance of appropriate training for health care professionals and of support for the families of those with dementia.

The representative of the INTERNATIONAL COUNCIL OF NURSES, speaking at the invitation of the CHAIRMAN, said that dementia should be mainstreamed as a component of noncommunicable disease policies. She supported the development of draft a global action plan on dementia, which should promote public awareness and people-centred care, support the provision of specialist training for health professionals, reduce the costs of dementia and include strategies to

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

safeguard patient safety. Member States should prioritize the development of national plans to support dementia patients, their families and communities.

The DIRECTOR-GENERAL said that there appeared to be a consensus on the need to include specific references to awareness-raising, early detection and diagnosis, and research and development in the draft global action plan on the public health response to dementia. The Secretariat would take into account regional and national best practices in the field and would present the Board with a draft document at the earliest possible opportunity. It would also strive to link the draft global action plan on dementia to other relevant policy instruments, including the Comprehensive Mental Health Action Plan 2013–2020, the global action plan for the prevention and control of noncommunicable diseases and the global strategy and action plan on ageing and health.

The Board noted the report.

At the request of the CHAIRMAN, the SECRETARY read out the proposed amendments to the draft decision. The words “to establish prevention measures,” should be added after “necessary policies and resources” in paragraph (1). The phrase “including the strategies outlined in paragraph 18 of document EB139/3, with clear goals and targets,” should be inserted after “health response to Dementia” in paragraph (2).

The decision, as amended, was adopted.¹

Improving access to assistive technology: Item 6.2 of the agenda (document EB139/4)

The representative of PAKISTAN, speaking on behalf of the Member States of the Eastern Mediterranean Region said that access to assistive technology was of particular concern in areas of the world facing conflict, violence and natural disasters. The dramatic growth of the global population and the rise in noncommunicable diseases was also increasing the need for high-quality, affordable and safe assistive products. He therefore urged Member States to devise national assistive technology programmes aimed at improving the availability, accessibility, affordability, appropriateness and accountability of assistive devices. He welcomed the launch during the Sixty-ninth World Health Assembly of a priority assistive products list modelled along the lines of the WHO Model List of Essential Medicines, which would serve as a catalyst for improving access to assistive products at all levels. He invited the regional committees to discuss the availability of assistive technology in more depth at their forthcoming meetings and called on the Board to prepare a draft resolution on access to assistive products for consideration by the Seventieth World Health Assembly.

The representative of COLOMBIA said that guidance would help to promote autonomy and access to high-quality assistive technology, and he supported the inclusion of assistive technology as an item on the agenda of the next World Health Assembly. His country had adopted a community-based rehabilitation approach involving multidisciplinary teams and he called on WHO to strengthen its technical assistance, including in developing standards to increase access to assistive technology. He welcomed the development of the WHO priority assistive products list and stressed the importance of ongoing efforts to implement the Global Cooperation on Assistive Technology initiative.

The representative of MEXICO said that assistive technology also had socioeconomic benefits by enabling a more active, productive and socially integrated population. Access to assistive technology remained a challenge, and he called for efforts to increase funding, research and

¹ Decision EB139(1).

development and the provision of ongoing training for health care professionals. Specific plans and programmes should be developed with a view to reducing costs, increasing technology transfer and promoting research and development. In Mexico, partnerships with civil society had been particularly beneficial in encouraging the use of assistive technology among those in need.

The representative of KUWAIT said that demand for assistive technology would continue to rise as populations aged and the prevalence of noncommunicable diseases increased. He asked whether mechanisms had been established to monitor the results of activities detailed in paragraphs 23 to 28 of the report.

The representative of BHUTAN said that persons with disabilities faced persistent barriers in accessing health services and rehabilitation and were, in many cases, forced to pay for assistive devices themselves. In order to increase access to assistive technology, in particular in developing countries and regions, WHO and other development partners should help to make such devices available at an affordable cost.

The representative of THAILAND said that sustainable and equitable access to safe, high-quality, cost-effective and acceptable assistance technologies should remain a priority and called on governments to provide an enabling environment for persons with disabilities.

The representative of KAZAKHSTAN said that greater attention should be paid to ensuring that children had access to affordable and appropriate assistive technology. Efforts should also be made to strengthen the network of national specialist referral and rehabilitation centres as a priority aspect of national health protection plans, particularly in countries with limited resources. He therefore called on WHO to continue its efforts in the area of assistive technology. The issue should be considered at the Seventieth World Health Assembly, where items 6.1, 6.2 and 6.3 of the Board's current agenda, which were closely related, might be considered together.

The representative of NEW ZEALAND said that all documents considered by the Board should contain proposed strategies with associated draft resolutions or decisions, together with an analysis enabling all Member States, irrespective of size, to see how implementation could deliver the best value. The focus should remain on public health; all new strategies and plans should be linked to the delivery of existing ones, as well as to global goals such as universal health coverage, and should take the varying needs and capacities of Member States into consideration. A list of graded actions for adoption and implementation by all Member States, irrespective of their health infrastructure should be provided and would facilitate the achievement of universal health care. Using the WHO Model List of Essential Medicines as an example would help to ensure increased access to a wide range of affordable, standardized assistive devices that addressed the priority needs of communities. WHO should apply its knowledge with respect to essential medicines to assistive technologies.

The representative of the CONGO, speaking on behalf of the Member States of the African Region, said that there were significant challenges in providing assistance to people with reduced mobility and disabilities, and noted that the situation was being exacerbated by the rise in noncommunicable diseases and multiple conflicts in the Region. Many African hospitals and health centres had not been designed for, or adapted to, the needs of people with disabilities, and mobile medical units should be created to facilitate access to the necessary treatment. WHO should provide support to strengthen the capacity of Member States to: carry out reconstructive surgery; increase the availability of assistive technology through welfare systems; and reduce the cost of accessing such technology. He agreed that some items on the Board's current agenda should be considered together at the Health Assembly.

The representative of the UNITED STATES OF AMERICA expressed appreciation for the report, but would have welcomed the inclusion of information on the impact of interventions on

individual employability or productivity for people with disabilities. His Government supported the Global Cooperation on Assistive Technology initiative, as well as the recently launched priority assistive products list. He would welcome the opportunity to consider a draft resolution on the item at the 140th session of the Board.

The representative of the DEMOCRATIC REPUBLIC OF THE CONGO said that access to assistive technology could only be improved by making further progress in the achievement of universal health coverage. Member States should be encouraged to select a package of interventions that would have the greatest impact, in order to end preventable deaths among vulnerable groups, and should ensure that actions to improve access to assistive technology were integrated within the package, which should be fully costed at the country level. WHO should take a leadership role in bringing together all stakeholders to align efforts and promote synergies in order to mobilize the necessary resources to improve access to assistive technology.

The representative of TURKEY acknowledged that there appeared to be consensus on including the current item on the agenda of the 140th session of the Board. The large number of products contained in the recently launched assistive priority products list might prove to be prohibitive, especially for low-income and developing countries. Noting the need to raise awareness of the issue of accidents in the home, he said that products related to the prevention of injuries in the home might also be included in the list, and asked whether a resolution already existed on that issue.

The representative of SOUTH AFRICA,¹ welcoming the Secretariat's proposals on access to assistive technology, noted that the barriers to access, in particular financial barriers, should be accorded special attention. Recalling programmes being implemented by her Government to improve access to assistive technology, she welcomed the support to be provided to Member States and looked forward to further collaboration with WHO.

The ASSISTANT DIRECTOR-GENERAL (Health Systems and Innovation) said that the Secretariat, which recognized the huge growing and unmet need for assistive technology worldwide, was coordinating the recently established Global Cooperation on Assistive Technology initiative. Cognizant of its role and responsibilities, WHO was developing practical tools to support Member States in ensuring access to assistive technology, such as the recently launched priority assistive products list, as well as the assistive technology policy framework and training package, and the single-window assistive products service provision. By supporting the item, Member States would be supporting improved access to high-quality, affordable assistive products delivered with integrated health services and as part of universal health coverage, alongside medicines and vaccines. In addition, supporting the item would also help Member States to realize their commitment to the United Nations Convention on the Rights of Persons with Disabilities and various WHO resolutions, notably those on ageing, disability and noncommunicable diseases. The Secretariat looked forward to further discussion of the item at the meetings of the governing bodies and to guidance from Member States towards the goal of universal access to assistive technology.

The CHAIRMAN took it that the Board wished to note the report. Noting the already heavy agenda of the 140th session of the Board, he proposed that the item should be included in the "rolling agenda" of the Board. The item would be taken up again, on the basis of the Board's prioritization of items on that agenda.

It was so agreed.

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

Development of a new Health Assembly resolution and action plan for prevention of deafness and hearing loss: Item 6.3 of the agenda (documents EB139/5 and EB139/5Add.1)

The CHAIRMAN invited the Board to consider the report contained in document EB139/5, including the draft resolution contained therein. The financial and administrative implications were set out in document EB139/5Add.1.

The representative of COLOMBIA noted the importance of raising awareness and developing preventive strategies to control exposure to environments that induced hearing loss. It was essential to build institutional capacity at the country level in order to implement detection programmes and provide access to hearing aids, as well as to train human resources, and he drew attention to measures taken by his Government in that regard. He highlighted the need to adopt a global action plan to promote quiet environments, noting the effect of excessive noise exposure on hearing loss, and would welcome consideration of the draft resolution by the Seventieth Health Assembly.

The representative of the PHILIPPINES recognized the magnitude of the problem of hearing loss and deafness, its economic implications and impact on quality of life. She agreed with the actions for Member States. It was essential to adopt a holistic approach by integrating strategies for ear and hearing care in health systems, noting for example the role played by immunization in preventing hearing loss, and called for guidance to be provided thereon. Paragraph 2(2) of the draft resolution might be amended to include reference to the development of an algorithm in order to help Member States integrate preventive strategies for ear and hearing care across programmes, such as those for maternal and child health, thereby highlighting the importance of a holistic approach.

The representative of TURKEY expressed support for the draft resolution and said that his country wished to be added to the list of sponsors.

The representative of the CONGO said that deafness and hearing loss posed a significant problem in low-income countries. He underscored the need to raise awareness of congenital malformations, which caused most cases of deafness and hearing loss among children. Support should be provided to enable Member States to implement preventive strategies, particularly in relation to pregnant women, including by ensuring that they received the necessary immunization, and by raising awareness of the dangers of alcohol consumption during pregnancy. WHO should also help countries in: developing early detection methods; strengthening detection actions at the community level; providing specialist training for health professionals; strengthening technical health facilities; and reducing the cost of cochlear implants. The issue of deafness and hearing loss should form part of the discussion on disabilities at the next Health Assembly. He expressed support for the draft resolution.

The representative of CHINA acknowledged the support provided by the Secretariat to assist Member States in developing robust measures to tackle deafness and hearing loss, and called on WHO to continue to raise awareness of the issue among the international community. Her Government had participated actively in international efforts to tackle the issue; three of the seven WHO collaborating centres for prevention of deafness and hearing loss were located in China. She expressed support for the draft resolution.

The representative of CANADA, noting the importance of preventive strategies to tackle hearing impairment, said that the establishment of a global strategy would help Member States in developing a national approach to the issue. She welcomed the proposed actions, which were aligned with her country's approach, including in relation to raising awareness, implementing screening programmes, and providing access to hearing devices. The draft resolution should refer to the national circumstances and priorities of Member States, and she suggested that paragraph 1 could be amended to read: "URGES Member States, taking into account their national circumstances".

The representative of BHUTAN, said that speech and hearing impairment was the most prevalent impairment in Bhutan. He endorsed the draft resolution and called on WHO to provide Member States with support in mobilizing adequate resources to translate strategies and plans into action.

The representative of VIET NAM noted the significant burden of disease from hearing loss, particularly in low-and middle-income countries. Ensuring access to hearing aids was particularly difficult in remote and inaccessible areas. He strongly supported integrated strategies for prevention and early detection, but noted that countries might face challenges in implementing some aspects of the draft resolution, especially given limited national data available and the difficulty in determining which interventions to include in the benefits package to be provided to those with deafness or hearing loss. He expressed support for the draft resolution; the toolkit of technical support to be developed should recognize the varying capacities of Member States.

The representative of the DOMINICAN REPUBLIC drew attention to the problem of noise-induced hearing loss, including through unsafe use of audio devices, especially among adolescents and young people. Detection strategies should be integrated into health systems to ensure early identification of hearing loss. It was also important to raise awareness of the issue and implement legislation to prevent exposure to environments that induced hearing loss. He said that his Government, which recognized the importance of ensuring access to assistive hearing technologies, wished to be added to the list of sponsors of the draft resolution.

The representative of the RUSSIAN FEDERATION said that many countries had made significant progress in tackling the issues related to deafness and hearing loss in the 20 years since the adoption of resolution WHA48.9 on prevention of hearing impairment. In the Russian Federation, hearing screening programmes were an essential component of the health care provided to infants. However, many people with deafness and hearing loss, especially children, still did not have access to the appropriate hearing care, partly due to the lack of trained human resources. Noting the importance of the issue, she urged WHO to accelerate and expand efforts to tackle deafness and hearing loss. She reiterated her country's willingness to collaborate with other countries in addressing the issue and expressed support for the draft resolution.

The representative of THAILAND suggested some amendments to the draft resolution. In paragraph 1(1), the words "under the umbrella of universal health coverage" should be inserted after "primary health care systems", and the words "and intersectoral collaboration" should be added at the end of the paragraph. She also proposed the insertion of the ", cost-effective," after "affordable" in the first line of operative paragraph 1(6), and the addition of "taking into account the delivery capacity of health care systems in an equitable and sustainable manner" at the end of the paragraph.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND said that the issue of deafness and hearing loss was linked to other items on the agenda, such as assistive technology and dementia. While poor sound protection was placing people at risk of developing hearing loss, the issue was also gaining importance in the context of aging populations. She would welcome a new resolution focused primarily on preventing hearing loss and improving the outcomes of those affected, including through education and employment opportunities. She asked whether the item should be considered at the 140th session of the Executive Board in the context of discussion of the rolling agenda.

The representative of MEXICO, noting that some 60% of hearing loss in children could be prevented, highlighted the profound impact of hearing loss, particularly among children, and noted that an early detection and intervention programme was being implemented for children under five years in Mexico as part of a universal health coverage strategy. The social and economic impact of deafness or hearing loss should not be underestimated. Political commitment was important, as was

the technical cooperation of WHO in helping countries to develop comprehensive policies on prevention, control and rehabilitation. Mexico would welcome adoption of the draft resolution for submission to the Seventieth World Health Assembly.

The representative of the UNITED STATES OF AMERICA pointed out that the earphones used in sessions of the Executive Board were incompatible with hearing aids; adapting them would be a practical step to enable people with hearing loss to participate more fully in the meeting. Noise-induced hearing loss applied to both recreational and occupational settings, and was a common work-related illness. He supported the draft resolution, and proposed a new preambular paragraph *4bis*, reading as follows: “Acknowledging the significance of work-related, noise-induced hearing loss, in addition to issues related to recreational and environmental noise-induced hearing loss”.

The representative of NEW ZEALAND, said that the Executive Board should prioritize the implementation of resolutions with due regard to cost-effectiveness, rather than asking Member States to prioritize implementation taking into account their national circumstances. He would welcome inclusion of the item on the rolling agenda of the Executive Board.

The representative of GERMANY¹ said that the action plan for prevention of deafness and hearing loss should promote the inclusion of individuals already living with hearing disabilities and reflect relevant elements of the 2030 Agenda for Sustainable Development and the Sendai Framework for Disaster Risk Reduction. Outlining the twin track approach taken by her country to support partner countries in implementing the Convention on the Rights of Persons with Disabilities, she said that Germany strongly welcomed initiatives for improved data collection and use, particularly as census and population data in many countries excluded data on the inclusion of persons with disabilities.

The representative of SOUTH AFRICA¹ said that appropriate, high-quality hearing devices were inaccessible to many because of supply and pricing constraints. Highlighting the importance of preventive measures, including through the rational use of ototoxic medicines, she said that childhood hearing loss must be addressed. In South Africa, children from low-income backgrounds were being assessed for deafness and hearing loss, and audiologists, speech and hearing therapists were appointed to prevent long-term hearing loss. She said that her country wished to be added to the list of sponsors of the draft resolution.

The representative of ZAMBIA¹ welcomed the development of an action plan. His country continued to face challenges related to deafness and hearing loss, particularly among people living in rural areas, but a lack of relevant data made it difficult to ascertain the full magnitude of the problem. Collaboration and technical support from WHO would be welcome, particularly in: conducting nationwide surveys and encouraging the regular monitoring and reporting of cases; raising awareness among the population and health care workers, especially of work-related hearing loss in the mining industry; training personnel in early detection; and procuring equipment for the screening process. His country was considering revising its relevant national public policies and legislation, including in addressing the playing of extremely loud music in public places.

The representative of SAUDI ARABIA¹ said that the integration of ear care in the primary health care system was essential for early identification, management and rehabilitation of hearing loss. He called for increased investment to build capacity and encourage the retention of trained professionals, adequate health information systems to provide evidence for monitoring implementation and policy-making, and a standardized approach for the prescription and use of

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

various hearing devices. Partnerships and innovations should also be explored in order to make such devices affordable to all in need.

The representative of INDIA¹ said that it was important to recognize that countries were at different levels of development, had varying levels of resources and were experimenting with different models of universal health coverage. Efforts should be made to identify innovative solutions to promote the development of user-friendly, high-quality and affordable assistive hearing technologies and products, and to promote technology transfer. He said that his country would welcome the adoption of the draft resolution for submission to the Seventieth World Health Assembly.

The representative of ALGERIA supported the draft resolution. However, if Member States were to ensure the highest possible coverage of vaccination against rubella, measles, mumps and meningitis, as they were urged in paragraph 1(4), sufficient quantities of those vaccines should be available worldwide. Technical support in many areas would be essential to the success of the action plan. Accordingly, paragraph 2(2) should be amended to begin “to develop a toolkit, as well as provide the necessary technical support”.

The representative of the INTERNATIONAL SOCIETY OF AUDIOLOGY, speaking at the invitation of the CHAIRMAN, said that while the lives of those affected by hearing loss could be greatly enhanced through the appropriate use of hearing devices, many people with hearing loss lived in low-income areas and were unable to access the required services. Hearing loss was not confined to the elderly; occupational noise was a cause of irreversible hearing loss, and exposure to loud sounds through headphones presented a new challenge. Noting that WHO and its Member States should pay greater attention to the issue of hearing loss, he expressed strong support for the draft resolution.

The DIRECTOR (Department for Management of Noncommunicable Diseases, Disability, Violence and Injury Prevention) thanked the Russian Federation for bringing the issue to the attention of the governing bodies some 20 years after it had last been discussed by the Board. Hearing loss had a profound impact on communication, literacy, employment, self-esteem, social skills and economic growth, but with early intervention and timely and appropriate interventions its impact could be minimized. WHO had scaled up its work on hearing loss in recent years, and had initiated global advocacy campaigns such as World Hearing Day and a “Make Listening Safe” initiative. It had also helped several countries to integrate ear and hearing care into their health systems, and would be continuing its work.

The Board noted the report.

The CHAIRMAN, supported by the representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, suggested that it should be left to the Executive Board at its 140th session to decide, on the basis of its consideration of the rolling agenda of the governing bodies, to which Health Assembly the Director-General should report on progress in implementation of the resolution. Accordingly, no session of the World Health Assembly would be specified in paragraph 2(5); an explanatory footnote would be inserted.

It was so agreed.

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

At the invitation of the CHAIRMAN, the SECRETARY read out the amendments proposed. A new preambular paragraph *4bis*, should be added to read “Acknowledging the significance of work-related, noise-induced hearing loss, in addition to issues related to recreational and environmental noise-induced hearing loss”. The words “with preventive strategies” should be added after “hearing loss are avoidable” in the seventh preambular paragraph. Paragraph 1 should read “URGES Member States, taking into account their national circumstances”. In paragraph (1), the words “under the umbrella of universal health coverage” should be added after “primary health care systems”, and the words “and intersectoral collaboration” should be inserted at the end of the paragraph. In paragraph 1(6) “, cost-effective,” should be added after “affordable” and the words “taking into account the delivery capacity of health care systems in an equitable and sustainable manner” should be inserted at the end of the paragraph. The beginning of paragraph 2(2) would read “to develop a toolkit, as well as provide the necessary technical support for Member States in collecting data, planning national strategies for ear and hearing care, specifying how prevention of hearing loss can be integrated in other health care programmes, raising awareness ...”.

The resolution, as amended, was adopted.¹

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

The CHAIRMAN invited the Executive Board to consider the report on health and climate change in document EB139/6. The Board was requested to provide guidance on the updated strategic priorities outlined in paragraphs 8 to 14 of the document.

The representative of LIBERIA, speaking on behalf of the Member States of the African Region, said that efforts were being made by the Region to increase health resilience to climate risk by prioritizing mitigation actions that also improved health. He took note of the revised strategic priorities, which had been updated in light of the Paris Agreement commitments. Although many Member States in the African Region were particularly vulnerable to the health impacts of climate change, they lacked the technical capabilities to design and implement health-related climate change plans. Support for policies, adaptation and mitigation plans within the context of the 2030 Agenda for Sustainable Development would be therefore be appreciated.

The representative of the RUSSIAN FEDERATION said that environmental issues could not be addressed by the health sector alone, climate change effects also came within the remit of other ministries, departments and organizations. Referring to paragraph 13 of the report, she said that a multisectoral approach to data collection on climate change was essential.

The representative of NEPAL, speaking on behalf of the Member States of the South-East Asia Region, said that the Region faced a continuous onslaught of natural disasters, which impacted on water quality and quantity and thus affected hygiene, resulting in disease outbreaks and hampering efforts to control diseases such as malaria. Concerted, coherent, multisectoral action was crucial. He called on all Member States to make more strategic efforts to prevent global warming. Technical assistance from WHO would be key to ensuring resilience to climate risk.

The representative of FRANCE supported the proposed strategic priorities. The health sector was implicated in both the mitigation and adaptation aspects of the response to climate change, and the health benefits of countering climate change should be underscored in order to encourage an intersectoral approach to the commitments undertaken in the Paris Agreement. Health systems must be

¹ Resolution EB139.R1.

strengthened to ensure resilience to climate change impacts; strong commitment from the health care community and efforts to raise public awareness would be necessary. The second Global Conference on Health and Climate, organized by WHO, would be hosted in Paris in July 2016.

The representative of CANADA said that her Government was committed to cooperating with international partners to take ambitious action to address climate change and protect the population from negative health effects, and to support other Member States in that regard. Evidence-based decision-making was particularly important and collaboration to build resilient health systems was welcome. Particular efforts should be made in the context of health for all to ensure that segments of society most vulnerable to the negative health impacts of climate change, such as indigenous peoples, were protected. Her delegation supported the view that climate change and health should be a standing item on the WHO agenda, with regular reporting to the World Health Assembly, since that approach would promote consistency and encourage Member States to track progress, and increase accountability and transparency.

The representative of FIJI said that climate change was an issue of great importance to small Pacific island nations, due not only to its health impacts, but to the risk it posed to the very survival of life itself. Climate change had already resulted in the loss of homes and lives in the Pacific islands, and the two degrees centigrade commitment was not sufficient. The effects of climate change were occurring so rapidly in the Pacific region that there was not time to wait until 2020 to galvanize efforts to curb climate change. Although a single climatic event could have a major public health impact in terms of outbreaks and could destroy a country's health care facilities, some change funds were not intended to cover health issues. That gap in assistance should be filled as a matter of urgency. He strongly supported the updated strategic priorities and called on WHO to work to raise awareness of the impact of climate change on health.

The representative of the PHILIPPINES said that Member States should be supported in their efforts to build resilient health systems and access funding to counter climate change. More information would be welcome on how WHO would help Member States to mainstream health in climate-related activities. Priority should be given to strengthening the evidence base and monitoring progress with regard to climate change and health.

The representative of THAILAND said that his delegation wished to table a draft decision on the adoption of a strategy and plan of action on climate change. He apologized for the late submission of the draft, which had been sponsored by eight Member States, but hoped that it could be considered.

Following a discussion in which the representatives of the PHILIPPINES, VIET NAM, KUWAIT on behalf of the Member States of the Eastern Mediterranean Region, the UNITED STATES OF AMERICA, BHUTAN, NEW ZEALAND, LIBYA, CHINA, KAZAKHSTAN, the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, SWEDEN, NEPAL, MONACO,¹ BANGLADESH,¹ ZAMBIA,¹ URUGUAY,¹ NORWAY,¹ CANADA and FRANCE, took part, in which it was suggested that the Secretariat should update the WHO Workplan on Climate Change and Health on the basis of the updated strategic priorities in document EB139/6, the representative of THAILAND withdrew his proposal.

The representative of VIET NAM said that climate change constituted a considerable challenge to human life. Low-and middle-income countries faced challenges with regard to the trade-off between economic development and emissions regulation, with air quality giving particular cause for concern

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

in countries with increasing industrialization. He welcomed the updated strategic priorities but considered that countries required assistance in strengthening the evidence base. Better support from developed countries providing foreign direct investment would be welcome, as would greater regional cooperation on the use of shared natural resources, such as the Mekong Delta.

The representative of the UNITED STATES OF AMERICA, welcoming efforts to strengthen the linkages between health and climate change, said that care should be taken to ensure that the continuation of the WHO global conference on health and climate change, as mentioned in paragraph 12 of the report by the Secretariat, should complement the regular meetings of the parties to the United Nations Framework Convention on Climate Change. Further information would be welcome on what WHO expected from accreditation to the Green Climate Fund, and on the agenda and goals of the second Global Conference on Health and Climate, to be held in Paris in July 2016.

The representative of BHUTAN said that extreme weather conditions in the Himalayas were having a considerable impact on health, and rising sea levels in South-East Asia were causing displacement and affecting major sectors of the economy, such as fisheries and tourism, with projected losses that an economy such as Bhutan's would not be able to support. Vulnerability to outbreaks of climate-sensitive diseases, such as cholera, dengue fever and malaria, was increasing. Turning to the updated strategic priorities, he said that particular attention should be paid to strengthening health systems, providing support for climate change adaptation measures, and enhancing emergency preparedness and response.

The representative of MEXICO, noting that some of the varied impacts of climate change on health were already being observed, welcomed the references to health in the Paris Agreement. WHO's participation in international events on environment and climate change-related issues would be a particularly important means of underscoring the links with health. Progress reports should be linked with other relevant WHO documents on environment and health.

The representative of NEW ZEALAND said that the report did not consider the use of the Sendai Framework for Disaster Risk Reduction as a tool for Member States, and did not pay sufficient attention to the increased pressure that weather events placed on certain regions. Member States at particular risk of harm from climate change should be encouraged to develop the infrastructure necessary to deliver universal health coverage and fully implement the International Health Regulations (2005). Lastly, contingency planning for climate change and health must address loss of habitat and land.

The representative of LIBYA, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that health professionals should attach higher priority to climate change, which was still considered as a peripheral issue. The potential negative impacts of climate change on health fully justified the need for relevant action and national commitments. The 22nd session of the Conference of the Parties to the United Nations Framework Convention on Climate Change, to be held in Morocco in November 2016, would provide an opportunity to highlight the health component of climate change, and he requested the Secretariat to provide information on the meeting. It would be useful to know whether WHO planned to facilitate access to international climate financing for the health sector through the Green Climate Fund.

The representative of CHINA said that air pollution, climate change and health were closely linked, and the adaptive capacities of health systems needed to be strengthened to address climate change. Synergy existed between work on health impacts and control effectiveness, but greater communication and coordination between the sectors involved was required. WHO should increase financial and technical support to Member States, as many lacked the technology necessary for synergy, policy development and assessment.

The representative of ALGERIA, while fully endorsing the strategic priorities put forward in the report, said that the role of the Executive Board must be clearly defined, given the increasing importance of climate change and its impact on health. Referring to paragraph 14 of the document, he said that the Board should provide periodic reports on climate change and health to the Health Assembly.

The representative of KAZAKHSTAN said that the loss of the Aral Sea had led to desertification and a decline in the quality of drinking water in his country, which was adversely affecting the health of the population. Major flooding had also occurred in recent years. The issue of climate change and health should be regularly considered by the Board and the Health Assembly.

The representative of COLOMBIA said that the chikungunya and Zika virus outbreaks in the Americas were clearly related to climate change and a lack of water. It was vital to address such epidemics, as they could become more frequent and affect large numbers of people. Paragraph 9 of the report should contain a specific reference to the need to promote and strengthen intersectoral action on climate change to reduce health risks. The strategic priorities for WHO should also cover raising awareness among the population of the risks of climate change, and of the connection between health and climate change among health personnel, and highlight the need for research on the impact on countries with different climatic zones, with a focus on adaptation and mitigation measures.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND said that regular reports on climate change and health should be submitted to the Executive Board.

The representative of SWEDEN asked what action was already being taken under the WHO Workplan on Climate Change and Health.

The representative of MONACO,¹ welcoming the strategic priorities, invited WHO to continue its work on climate change in cooperation with all relevant actors, while avoiding any duplication of efforts.

The representative of SWITZERLAND¹ said that the mitigation of climate change would help to promote the achievement of health objectives, including with respect to noncommunicable diseases and the Sustainable Development Goals. She called for integrated action at the international and national level and for efforts to develop synergies and make savings, and considered that climate change should be addressed in a holistic manner to reduce its impact on health. Her Government, which was actively promoting the link between the mitigation of climate change and health protection, welcomed the strategic priorities for WHO.

The representative of BANGLADESH¹ welcomed WHO's commitment to ensuring implementation of the health-related aspects of the Paris Agreement. Climate change was having an enormous impact on Bangladesh, and his Government hoped to receive a reasonable share of the international climate funding mobilized under the Agreement. A number of successful adaptation interventions were being undertaken in the country, including mitigation measures in coastal areas and the promotion of solar-based rural electrification.

The representative of ZAMBIA¹ said that droughts, floods and extreme temperatures caused by climate change were having a serious impact on the health system in his country. Outbreaks of cholera and malaria were becoming more frequent and were occurring in new areas; there were increased cases of malnutrition, and drought-induced power outages in health facilities were affecting the

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

delivery of services. He welcomed the strategic priorities for WHO and expressed his Government's willingness to work with other Member States and partners to mitigate the effects of climate change on health systems.

The representative of URUGUAY¹ welcomed the updated strategic priorities for WHO and requested the Secretariat to provide technical support to assist Member States in their efforts to address the health impact of climate change.

The representative of NORWAY¹ endorsed the updated strategic priorities for WHO set out in the report.

The representative of INDIA¹ emphasized that climate change goals must be pursued through the United Nations Framework Convention on Climate Change and the relevant institutional arrangements. His Government had finalized a mission to examine the impact of climate change on health in different regions of the country, and to build response capacity. Strategies that ignored the inextricable link between climate change, its adverse health impacts and socioeconomic factors could exacerbate existing health inequities. Noting that capacities and resources differed vastly among countries, he said that huge investment was required to ensure the large-scale, sustained adoption of clean technologies. In addition, global partnerships should facilitate technology transfer and resource mobilization. Lastly, the Secretariat should place adequate emphasis on adaptation to climate change.

(For continuation of the discussion, see the summary record of the third meeting, section 1.)

The meeting rose at 17:30.

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

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 MOROCCO¹ 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 VENEZUELA¹ 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 BRAZIL¹ 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 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 Development¹ 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 (2015).

The representative of COLOMBIA 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, 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 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 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.

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 health¹ 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 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 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.

¹ Document EB139/8.

The representative of TURKEY 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 JAPAN¹ 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 BANGLADESH¹ 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 GERMANY¹ 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 NORWAY¹ fully endorsed the statement made by the representative of the Netherlands on behalf of the European Union and its Member States.

The representative of ZAMBIA¹ 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.

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

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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, 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 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 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 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 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 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.

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 BANGLADESH¹ 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

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

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 ZAMBIA¹ 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 AFRICA¹ 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 INDIA¹ 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.

The representative of KENYA¹ 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 BRAZIL¹ 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 application 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.

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

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.

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 SWITZERLAND¹ 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

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

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.

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

¹ Decision EB139(2).

² Decision EB139(3).

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

- **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

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.”

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.

¹ Decision EB139(8).

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

The Board noted the report, agreed to the terms outlined by the Chairman to clarify the procedures, and approved the draft decision.¹

3. 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

¹ Decision EB139(9).

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 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 BRAZIL¹ 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

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

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.

The representative of ZAMBIA¹ 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

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

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 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.

4. 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 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 BRAZIL¹ 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.

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.

5. 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 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 EB139/13.²

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.

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

² Decision EB139(10) and decision EB139(11).

The representative of VIET NAM 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.

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 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.

6. 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.

LIST OF MEMBERS AND OTHER PARTICIPANTS

MEMBERS, ALTERNATES AND ADVISERS

MALTA

Dr R. Busuttil Consultant, Public Health, Ministry for Health Valletta (**President – Chairman**)

Alternates

Mr O.J. Terribile, Ambassador, Permanent Representative, Geneva

Dr M. Podesta, Resident Specialist, Public Health Medicine, Ministry for Health, Geneva

Mr M. Ciscaldi, First Secretary, Permanent Mission, Geneva

ALGERIA

Professeur S. Mesbah Directeur général, Prévention et promotion de la santé, Ministère de la santé, de la population et de la réforme hospitalière Alger

Alternates

M. B. Delmi, Ambassadeur, Représentant permanent, Genève

M. T. Djouama, Représentant permanent adjoint, Genève

M. M. Mansri, Sous Directeur, Développement social, Ministère des affaires étrangères et de la coopération internationale, Alger

M. S. Meziane, Conseiller aux Affaires étrangères, Mission permanente, Genève

M. F. Allek, Premier Secrétaire, Mission permanente, Genève

M. S. Rahem, Attaché, Mission permanente, Genève

Mlle K. Boukeha, Stagiaire, Mission permanente, Genève

Mlle L. Djerroud, Stagiaire, Mission permanente, Genève

BAHRAIN

Ms F.S. Alsaleh Minister of Health Manama

Alternates

Dr W.K. Al Manea, Deputy Assistant, Hospital Affairs, Manama

Dr M.I. El Hajry, Head, Public Health Department, Manama

Mr A.E. Mokle, Specialist, Public Relations, Manama

BHUTAN

Mr L.T. Wangchuk Minister of Health Thimphu

Alternates

Mr K. Singye Ambassador, Permanent Representative Geneva

Dr U. Dophu Director-General, Department of Medical Services, Ministry of Health Thimphu

Ms K. Wangmo, Planning Officer, Ministry of Health, Thimphu

Mr T. Dukpa, Minister, Permanent Mission, Geneva

Mr T. Dorji, Second Secretary, Permanent Mission, Geneva

BURUNDI

Dr I. Minani, Directeur général des services de santé et de la lutte contre le SIDA, Ministère de la santé publique et de la lutte contre le SIDA, Bujumbura (**alternate to Dr J. Nijimbere**)

Alternate

M. P. Minani, Conseiller, Mission permanente, Genève

CANADA

Ms S. Lawley, Director-General, Office of International Affairs for the, Health Portfolio, Ottawa
(alternate to Mr S. Segard)

Alternates

Ms R. McCarney, Ambassador, Permanent Representative, Geneva

Ms C. Godin, Deputy Permanent Representative, Geneva

Ms N. St Lawrence, Director, Multilateral Relations Division, Office of International Affairs for the Health Portfolio, Ottawa

Advisers

Mr K. Lewis, Consellor, Permanent Mission, Geneva

Ms C. Palmier, Counsellor, Permanent Mission, Geneva

Ms N. Zand, Health and Nutrition Officer, Permanent Mission, Geneva

Mr M. Baglole, Policy Analyst, Multilateral Relations, Office of International Affairs for the Health Portfolio, Ottawa

Ms N. Desrosiers, Policy Analyst, Multilateral Relations, Office of International Affairs for the Health Portfolio, Ottawa

Ms L. Forrest, Junior Policy Officer, Permanent Mission, Geneva

CHINA

Ms Zhang Yang, Deputy Director-General, Department of International Cooperation, National Health and Family Planning, Commission, Beijing

Alternate

Ms Li Juan, Programme Officer, Department of International Cooperation, National Health and Family Planning Commission

COLOMBIA

Dr F. Ruiz Gómez, Viceministro de Salud Pública y Prestación de Servicios, Ministerio de Salud y Protección Social, Bogota

Alternates

Dra. B. Londoño Soto, Embajadora, Representante Permanente, Ginebra

Sr. J. Matute, Coordinador, Cooperación Internacional, Ministerio de Salud y Protección Social, Bogota

Sr. G. Calderon, Coordinador, Asuntos Sociales, Ministerio de Relaciones Exteriores, Bogota

Sra. H. Botero Hernández, Primera Secretaria, Misión Permanente, Ginebra

Sra. M.P. Gomez, Asesora, Ministerio de Salud y Protección Social, Bogota

Sra. S. Arroyo Kogson, Pasante, Misión Permanente, Ginebra

CONGO

Professeur A. Elira Dokékias, Directeur général des Hôpitaux et de l'Organisation des Soins, Ministère de la santé et de la population, Brazzaville

Alternates

Dr A.S. Dzabatou Babeaux, Directeur, Maladies transmissibles et VIH/Sida, Brazzaville

Mme F. Mvila, Conseillère, Mission permanente, Genève

DEMOCRATIC REPUBLIC OF THE CONGO

Dr M. Kupa, Secrétaire général à la Santé, Ministère de la Santé publique, Kinshasa

DOMINICAN REPUBLIC

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Alternates

Dr. R.A. Lopez, Supervisor de Salud Colectiva, Santo Domingo

Sra. K. Urbáez, Ministra Consejera, Misión Permanente, Ginebra

FIJI

Mr J. Usamate, Minister for Health and Medical Services, Suva

Alternates

Ms N.S. Khan, Ambassador, Permanent Representative, Geneva

Mrs N. Khatri, Deputy Permanent Representative, Geneva

Dr I. Tukana, National Adviser, Noncommunicable Diseases, Ministry of Health, Suva

Mrs S. Waqa, Director, Nursing Services, Ministry of Health and Medical Services, Suva

Mr A.A. Pratap, First Secretary, Permanent Mission, Geneva

Mr R. Simona, Attaché, Permanent Mission, Geneva

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Professeur B. Vallet, Directeur général de la santé, Ministère des affaires sociales, et de la santé, Paris

Alternates

Mme E. Laurin, Ambassadeur, Représentant permanent, Genève

M. P. Meunier, Ambassadeur chargé de la lutte contre le Sida et les maladies transmissibles,
Ministère des affaires étrangères et du développement international, Paris

M. T. Wagner, Représentant permanent adjoint, Genève

Mme M. Diallo, Sous-directrice, Sous-direction du développement humain, Ministère des
affaires étrangères et du développement international, Paris

Mme E. Aronica, Déléguée adjointe, Affaires européennes et internationales, Ministère des
affaires sociales et de la santé, Paris

Mme A. Schmitt, Cheffe, Mission des affaires européennes et internationales, Direction
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Mme M.A. Mortelette, Conseiller Santé, Mission permanente, Genève

M. P. Damie, Conseiller Santé, Mission permanente, Genève

Mme J. Daeschler, Chargée de mission, Bureau santé protection sociale, Délégation aux affaires
européennes et internationales, Ministère des affaires sociales et de la santé, Paris

M. B. Redt, Chargé de mission, Sous-direction du développement humain, Ministère des
affaires étrangères et du développement international, Paris

M. P. Ramet, Conseiller, Environnement et transport, Mission permanente, Genève

Mme S. Peron, Conseillère, Questions budgétaires, Mission permanente, Genève

M. P. Le Goff, Deuxième Secrétaire, Mission permanente, Genève

Mme M. Courbill, Attachée, Santé, Mission permanente, Genève

M. S. Desramaut, Attaché de presse, Mission permanente, Genève

M. M. Beigbeder, Chargé de mission, Mission permanente, Genève

M. S. Brunet, Stagiaire ENA, Mission permanente, Genève

Mme N. Maschio-Esposito, Stagiaire au Pôle santé, Mission permanente, Genève

Mme M. Jacquot, Stagiaire au Pôle santé, Mission permanente, Genève

GAMBIA

Dr S. Ceesay, Acting Director, Health Services, Ministry of Health and Social Welfare, Banjul
(alternate to Mr O. Sey)

JAMAICA

Mr W. McCook, Ambassador, Permanent Representative, Geneva **(alternate to Dr C. Tufton)**

Alternates

Dr W. De La Haye, Chief Medical Officer, Ministry of Health, Kingston

Dr M. Coombs, Regional Technical Director, Southern Regional Health Authority, Kingston

Ms C. Gordon, Deputy Permanent Representative, Geneva

Ms A.G. Timberlake, Director, International Cooperation in Health, Ministry of Health,
Kingston

Mrs P. Laird-Grant, Minister Counsellor, Permanent Mission, Geneva

Mrs M. Lawson Byfield, Chief Nursing Officer, Ministry of Health, Kingston

Mrs J. Farr, President, Nurses Association, Kingston

Ms L. Salmon, First Secretary, Permanent Mission, Geneva

Ms D. McFarlane, Health Specialist, Planning Institute, Kingston

JORDAN

Ms S. Majali, Ambassador, Permanent Representative, Geneva **(alternate to Dr A. Hyasat)**

Alternates

Dr M. Tarawneh, Director, Planning Administration, Amman

Dr B. Alqaseer, Director, Primary Health Care Administration, Amman

Mr H. Maaitah, Second Secretary, Permanent Mission, Geneva

KAZAKHSTAN

Professor M. Kulzhanov, Kazakhstan School of Public Health, Ministry of Healthcare and Social
Development, President of the Medical Chamber of Kazakhstan, Astana

KUWAIT

Dr J. Alharbi, Assistant Undersecretary for Support Medical Services, Ministry of Health, Kuwait City
(alternate to Dr A.S. Al-Obaidi)

Alternate

Dr K. Alanzi, Chief, International Health Agreements, Ministry of Health, Kuwait City

LIBERIA

Dr B.T. Dahn, Minister of Health and Social Welfare, Monrovia

Alternates

Dr F.N. Kateh, Deputy Minister for Health Services and Chief Medical Officer, Ministry of
Health, Monrovia

Mr P.W. Tate, Chargé d'affaires a.i., Permanent Mission, Geneva

Mr J.K. Shakpeh, Nursing Director, Redemption Hospital, Monrovia

Dr J.S. Doedeh, County Health Officer, Sinoe County, Monrovia

LIBYA

Dr R. Eloakley, Tripoli

Alternates

Dr S. Eldaghili, Chargée d'affaires a.i., Permanent Mission, Geneva

Mr A. Alakhder, First Secretary, Permanent Mission, Geneva

Dr A.A.W.H. Husayn, Counsellor, Health, Permanent Mission, Geneva

Dr I. Elwasea, Director, Minister's Office, Ministry of Health, Tripoli

Dr A.A. Almokhtar, Head, Human Resources Department, International Cooperation Office,
Ministry of Health, Tripoli

MEXICO

Sr. J. Lomónaco, Embajador, Representante Permanente, Ginebra (**alternate to Ms H. Dávila Chávez**)

Alternates

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