

FIFTH MEETING

Wednesday, 21 January 2009, at 14:05

Chairman: Mr N.S. DE SILVA (Sri Lanka)

TECHNICAL AND HEALTH MATTERS: Item 4 of the Agenda (continued)

Primary health care, including health system strengthening: Item 4.5 of the Agenda (Document EB124/8) (continued)

Dr SEYER (World Medical Association), speaking at the invitation of the CHAIRMAN, and on behalf of the World Health Professional Alliance, said that the Alliance represented national associations in more than 150 countries and the collective views of more than 25 million health professionals. Welcoming the report, she emphasized the value of well-functioning health-care systems for sustained economic and social development, improving quality of life and fostering world peace. In recent years, the health-care sector had become a major sector in national economies. Health-care systems constituted the pillars of national economies. Building health-care systems around primary care and making that the core of a comprehensive approach was a meaningful and rational strategy. Primary care brought health care close to where people lived and worked. It needed to be sustained by integrated referral systems and regarded as a policy direction for all countries.

The Alliance emphasized the need to broaden the report's strategic directions. Universal care would require comprehensive health-care systems founded on strong primary care structures. That would give all seriously ill patients a chance to receive treatment, would attract health professionals, and underlay sustainable economic development.

Dr COMETTO (Save the Children), speaking at the invitation of the CHAIRMAN, said that the establishment of equitable health systems with high-quality services was at the heart of his organization's strategy, and that WHO was an important ally in pursuing that objective.

At the global level, there was an opportunity to streamline health aid and make it more responsive to the needs of women and children by strengthening health systems with, if necessary, new aid instruments. WHO should use its influence with initiatives such as the International Health Partnership and the High Level Task Force on Innovative International Finance for Health Systems. However, better alignment of external financing and more equitable allocation of domestic resources would be necessary.

Social, economic, cultural and financial barriers prevented populations in lower-income and middle-income countries from gaining access to health care. Reducing financial barriers by removing out-of-pocket payments could be one of the solutions. Payment for health care at the point of use had been shown to restrict access; it caused health expenditure that drove tens of millions of households below the poverty line each year, and adversely affected the wider social determinants of health.

In resolution WHA58.33 the Health Assembly had urged Member States to adopt financing systems based on risk pooling. Limited progress had been made and he urged renewed efforts to implement those recommendations.

Ms YANN (Oxfam), speaking at the invitation of the CHAIRMAN, said that she supported WHO's renewed commitment to primary health care backed by functioning health systems. She emphasized equity: the adoption of policies and practices, including financing and delivering health services, that improved the health of poor and marginalized people. The public provision of free health

services with essential medicines was the surest way to ensure health care for the poor. The quality of private provision varied between “five-star” hospitals and unqualified individuals selling medicines of low quality. Such extremes often failed, in terms of either equity or quality and safety. Therefore, WHO should seek empirical evidence on the nature and efficiency of private providers, and the use of their services by poor people. WHO should also avoid conflating private for-profit organizations with nongovernmental and faith-based organizations. The private sector should complement, but not undermine, public health systems.

Dr ETIENNE (Assistant Director-General) thanked speakers for their commitment to the renewal of primary health care and strengthening of health systems. Discussions at six regional consultations, the thirtieth anniversary celebrations of the Declaration of Alma-Ata and regional committee meetings had guided the formulation of the report and the recommendations for a related resolution. The Secretariat remained fully committed to the primary health-care strategy in achieving improved health outcomes, the Millennium Development Goals, and the highest standards of health. That approach was relevant to all countries and at every stage of the development process.

Speakers had emphasized the strategy’s four policy directions. Some had also mentioned universal coverage, social protection in the form of fee or pool payment schemes, and sustainable health financing. She had taken note of those statements and on the need for service delivery to encompass all levels of care, from the community to more specialized services, and to be responsive to people’s needs and expectations, through comprehensive and integrated delivery.

Responding to a question from the member for the United States on moving health care close to communities, she said that the concept of geographical accessibility should also encompass, *inter alia*, location, culture, suitability, participation and accountability.

There had been calls for “health in all policies” and references to the importance of health in all sectors. Inclusive and participatory approaches to governance and leadership had been emphasized, particularly the need to integrate and empower communities in decision-making.

She recognized that community participation and ownership should be strengthened when implementing the strategy. She had also taken note of the references made to strengthening the six building blocks: health financing, human resources for health, health information, governance, service delivery, and commodities.

The members for the Russian Federation and the Bahamas had commented that the report contained little analysis. That had been due to lack of space. However, a full analysis of the challenges and constraints could be found in both *The world health report 2008* and the report of the Commission on Social Determinants of Health. Remaining gaps in the analysis and evidence would be filled during ongoing implementation of the strategy. The Secretariat would ensure that primary care was brought into the mainstream of the Organization’s work. She confirmed that there would be a linkage between the primary health-care strategy and the social determinants of health. A greater responsiveness to countries’ needs and enhanced technical assistance in country support programmes were also required. The Secretariat would fulfil its leadership role in future implementation of the strategy. She would work with Member States to revise the documentation, and on implementing health systems based on primary health care.

The Board took note of the report.

The CHAIRMAN drew attention to the draft resolution on traditional medicine proposed by China, which had been introduced in the previous meeting.

Dr REN Minghui (China) said that the Declaration of Alma-Ata in 1978 had called for traditional medicines to be included in national health systems. Nowadays, despite all the new technology available, the popularity of traditional medicine was increasing. Traditional medicines were already widely used in Africa, Asia and Latin America. In developed countries, such as Canada,

France and the United States of America, more people were turning to traditional medicine as its efficacy and safety became recognized. The number of countries in which traditional medicines were used had increased from five to 39 between 1990 and 2007; the number of Member States with applicable legislation had increased from 14 to 86 between 1980 and 2003; and the number of Member States with research institutes in the field had increased from 12 to 56 between 1970 and 2007. Norway, Singapore and the United Kingdom of Great Britain and Northern Ireland already had legislation on traditional medicine and other countries sought to introduce traditional medicines into their health systems, but lacked the necessary expertise. The Beijing Declaration on Traditional Medicine had been adopted at the WHO Congress (Beijing, 7–9 November 2008). The draft resolution on traditional medicine reflected the conclusions of the Conference. So far, 11 Member States had expressed their wish to add their names to the list of sponsors. The draft resolution should be adopted so that it could be submitted to the Sixty-second World Health Assembly.

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, thanked the member for China for bringing such an important subject to the Board's attention. He fully recognized the importance of traditional medicine around the world. However, the draft resolution ought to allow Member States to comply flexibly with their own national health systems and priorities. It would be preferable to use the WHO definition of traditional medicine in order to avoid duplication of the Beijing Declaration, particularly in paragraph 1. In addition, he wished to propose the following amendments: that in subparagraph 1(1) "URGES" should be replaced by "INVITES"; in subparagraph 1(2) the word "promote" should be deleted; in subparagraph 1(4) the words "to take action to integrate" should be replaced by "to consider the possibility to integrate"; in subparagraph 1(6) the beginning of the sentence should be changed to "to consider the possibility to establish systems for qualification ..."; and the words "in accordance with national capacities, priorities, relevant legislation and circumstances" should be added at the end of the sentence; in subparagraph 1(7) the language from point VI of the Beijing Declaration should be maintained, namely "the communication between the practitioners ... should be strengthened", and the following words "in accordance with national capacities, priorities, relevant legislation and circumstances" inserted thereafter; and subparagraph 1(8) should be deleted. The choice of traditional medicine day should be left to individual Member States. In subparagraph 2(3) the wording should be changed to "implement the Global Strategy", which included recommendations relating to traditional medicine.

Should those amendments be incorporated, the Member States of the European Union would be able to support the draft resolution.

Ms TOELUPE (Samoa), speaking as a cosponsor of the draft resolution, said that Samoa recognized traditional medicine as integral to accessible and affordable primary health care. National legislation had recognized traditional healers and birth attendants as health service providers, making them more accountable and ensuring safer practice. Samoa remained dependent on WHO to provide technical guidance on standards, research and sharing of information.

Dr JAYANTHA (alternate to Mr de Silva, Sri Lanka) said that his Government placed great emphasis on traditional medicine. It had established medical colleges awarding degrees in the subject and established a Ministry of Indigenous Medicine. More than 1500 medical graduates were employed by the Government in the sector, and the country had more than 15 000 practitioners of traditional medicine. He expressed support for the draft resolution and urged WHO to provide technical assistance to relevant countries in order to improve the safety, efficacy and quality of traditional medicine and the competence of its practitioners.

Dr KAMOTO (Malawi), speaking on behalf of the Member States of the African Region, expressed support for the draft resolution, which Malawi wished to cosponsor. Issues relating to traditional medicine affected the poor, the most vulnerable, and those without easy access to modern

health systems. The variation in therapies and practices from country to country could result in traditional medicine being practised in countries without the necessary regulatory framework, and leave them vulnerable to abuse. Fortunately, the recent Beijing Declaration on Traditional Medicine had established some standards in that area.

At the national level, Malawi was supporting and collaborating with traditional healers on tuberculosis, HIV and research into traditional medicine.

Ms HELA (South Africa),¹ speaking as a cosponsor of the draft resolution, suggested that the word “integrate” should be replaced by “include” throughout the text. Traditional medicine was used widely in Africa and was important for delivery of primary health-care services. She emphasized the development of appropriate standards in research into safety and equity; and of reliable instruments to assess traditional medicine’s effectiveness and potential value in the public health services. The institutionalization of traditional medicine within the health system needed to be supported by policy, legislative frameworks and resources.

Dr RAZAFINDRAZAKA (Madagascar)¹ said that traditional medicine was practised in Madagascar, notably in rural areas, and its advantages and disadvantages had been observed. In the current financial crisis, traditional medicine was an alternative that could not be ignored when responding to health problems. He therefore supported the draft resolution, with the exception of subparagraph 1(6) on the role of the State in licensing traditional medicine practitioners. Since reliable medical diagnosis required sound medical training, collaboration between traditional healers and physicians should be emphasized in the draft resolution.

At the request of Dr REN Minghui (China), the CHAIRMAN suggested that further discussion of the subitem should be deferred pending consideration of the proposed amendments.

It was so agreed.

(For adoption of the draft resolution, see summary record of the eleventh meeting, section 1.)

Commission on Social Determinants of Health: Item 4.6 of the Agenda (Document EB124/9)

The CHAIRMAN invited the Chairman of the WHO Commission on Social Determinants of Health to introduce the item.

Professor Sir Michael MARMOT (Chairman, Commission on Social Determinants of Health) said that the Commission had been set up in the service of equity and in recognition of the importance of taking action on the causes of illness. Simply expressed, the Commission had concluded that social injustice was killing people on a grand scale. Lack of universal access to health care was one of the important social determinants of health, and the Commission welcomed WHO’s renewed emphasis on primary health care. Nevertheless, primary health care and social determinants of health were mutually dependent. The Commission had established three action areas: daily living conditions; structural drivers, i.e., inequities in power, money and resources; and monitoring, research, evaluation and capacity building. Since the Commission had reported to the Director-General in August 2008, several WHO regions, in particular the Region of the Americas, had shown great interest in the Commission’s findings, and related meetings and follow-up were planned in some countries, including Sri Lanka and the United Kingdom of Great Britain and Northern Ireland.

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

The Commission had worked closely with civil society groups. Involving other agencies and elements of government in the work on social determinants was vital, and WHO had thus encouraged the United Nations Economic and Social Council to consider the work of the Commission.

The CHAIRMAN drew the Board's attention to a draft resolution and its financial and administrative implications for the Secretariat, which read as follows:

The Executive Board,
Having considered the Secretariat's report on the final report of the WHO Commission on Social Determinants of Health,¹

RECOMMENDS to the Sixty-second World Health Assembly the adoption of the following resolution and its financial and administrative implications:

The Sixty-second World Health Assembly,
Having considered the Secretariat's report on the final report of the WHO Commission on Social Determinants of Health;

Noting the 60th anniversary of the establishment of WHO in 1948 and its Constitution which affirms that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Noting the 30th anniversary of the International Conference on Primary Health Care at Alma-Ata in 1978 which reaffirmed the essential value of equity in health and launched the global strategy of primary health care to achieve health for all;

Recalling the principles of "Health for All", notably the need for intersectoral action (resolution WHA30.43);

Confirming the importance of addressing the wider determinants of health and considering the actions and recommendations set out in the series of international health promotion conferences from the Ottawa Charter on Health Promotion to the Bangkok Charter for Health Promotion in a Globalized World making the promotion of health central to the global development agenda as a core responsibility of all governments (resolution WHA60.24);

Noting the global consensus of the Millennium Declaration to achieve the Millennium Development Goals by 2015 and the concern at the lack of sufficient progress towards many of these goals in some regions at the half-way point;

Noting the publication of *The world health report 2008* on primary health care and its focus on ways to improve health equity by reforming health and other societal systems;

Mindful about the fact that responses to environmental degradation and climate change include health equity issues and noting that the impact of climate change is expected to negatively affect the health of vulnerable and disadvantaged populations (resolution WHA61.19);

Mindful about the facts concerning widening gaps in life expectancy worldwide;

Attaching utmost importance to the elimination of gender-related health inequalities;

Recognizing that millions of children globally are not reaching their full potential and that investing in comprehensive supports for early child development that are

¹ Document EB124/9.

accessible to all children is a fundamental step in achieving health equity across the lifespan;

Acknowledging that improvement of unfavourable social conditions is primarily a social policy issue;

Noting the need to improve coordination among global, national and subnational efforts in tackling social determinants of health through work across sectors, while simultaneously promoting social and economic development, with the understanding that such action requires the collaboration of many partners, including civil society and private sector,

1. EXPRESSES its appreciation for the work done by the Commission on Social Determinants of Health;
2. CALLS UPON the international community, such as United Nations agencies and intergovernmental bodies:
 - (a) to take note of the final report of the Commission on Social Determinants of Health and its recommendations;
 - (b) to take action in collaboration with the WHO Secretariat and Member States on assessing the impacts of policies and programmes on health inequalities and on addressing the social determinants of health;
 - (c) to work closely together with the WHO Secretariat and Member States on measures to improve health for the entire population and reduce inequalities through addressing social factors that influence health;
3. URGES Member States:
 - (a) to develop and implement goals and strategies to improve public health with a focus on health inequalities;
 - (b) to strengthen the role of public health in policy development to reduce health inequalities, including ensuring access to all aspects of public health: health promotion, disease prevention and health care;
 - (c) to strengthen efforts to achieve equitable access to public health interventions, including health promotion, disease prevention and health care for the entire population;
 - (d) to ensure dialogue and cooperation among relevant sectors and be a driving force for this cooperation with the aim of integrating a consideration of health into relevant public policies;
 - (e) to educate health providers on how to take social factors into delivering appropriate care to their patients;
 - (f) to contribute to the improvement of the daily living conditions of major importance for health and social well-being across the lifespan by involving all relevant partners, including civil society;
 - (g) to contribute to the empowerment of individuals and groups, especially those who are marginalized, and take steps to improve the societal conditions that affect their health;
 - (h) to develop or make use of existing methods and evidence, tailored to national contexts in order to address the social determinants and social gradients of health and health inequalities;
 - (i) to make use of, and if necessary, improve health information systems in order to monitor and measure the health of national populations, with data disaggregated according to the major social factors in each context (such as gender, ethnicity, education, employment and socioeconomic status) so that health inequalities can be detected and the impact of policies monitored;

4. REQUESTS the Director-General:
- (a) to work closely with partner agencies in the multilateral system on appropriate measures that address the social determinants of health and to advocate for this topic to be high on the global development and research agendas;
 - (b) to strengthen the capacity within the Organization with the purpose to give sufficient priority to relevant tasks related to addressing the social determinants of health in order to reduce health inequalities;
 - (c) to implement measures, including indicators for the monitoring of social determinants of health, across relevant areas of work and promote addressing social determinants of health to reduce health inequalities as an objective of all areas of the Organization's work, especially priority public health programmes;
 - (d) to ensure that ongoing work on the revitalization of primary health care addressing the social determinants of health is aligned with this, as recommended by *The world health report 2008*;
 - (e) to support Member States in implementing a health-in-all-policies approach to tackling inequalities in health;
 - (f) to support Member States, at their request, in implementing measures with the aim of integrating a focus on social determinants of health across relevant sectors and to design, or if necessary redesign, their health sectors to address this appropriately;
 - (g) to support Member States, at their request, in strengthening existing efforts on measurement and evaluation of the social determinants of health and the causes of health inequalities and to develop and monitor targets on health equity;
 - (h) to support research on effective policies and interventions to improve health by addressing the social determinants of health that also serve to strengthen research capacities and collaborations;
 - (i) to support the regional directors in developing a regional focus on issues related to the social determinants of health and in engaging a broader range of countries in this issue, in accordance with the conditions and challenges of each region;
 - (j) to prepare a global event, with the assistance of Member States, before the Sixty-fifth World Health Assembly in order to highlight the developments, progress and renewed plans for addressing the alarming trends of health inequalities and to increase global awareness on social determinants of health, including health equity;
 - (k) to report on progress in implementing this resolution to the Sixty-fifth World Health Assembly.

1. Resolution Reducing health inequalities through action on the social determinants of health	
2. Linkage to programme budget	
Strategic objective: 7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.	Organization-wide expected result: 7.1 Significance of social and economic determinants of health recognized throughout the Organization and incorporated into normative work and technical collaboration with Member States and other partners. 7.2 Initiative taken by WHO in providing opportunities and means for intersectoral collaboration at national and international levels in order to address social and economic determinants of health and to encourage poverty reduction and sustainable development. 7.3 Social and economic data relevant to health collected, collated and analysed on a disaggregated basis (by sex, age, ethnicity, income, and health conditions, such as disease or disability).

<p>(Briefly indicate the linkage with expected results, indicators, targets, baseline)</p> <p>Implementation of the resolution will greatly assist the ability of the Organization to integrate work on the social determinants of health into its programmes and to support Member States in developing national capacity to measure health inequities and implement intersectoral policies on the social determinants of health.</p>
<p>3. Financial implications</p> <p>(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 29 850 000 over the years 2009, 2010 and 2011.</p> <p>(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant) US\$ 9 760 000 covering work at headquarters level to extend existing activities, and work in regional offices to build capacity and facilitate regional efforts, in line with the resolution.</p> <p>(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009? All activities for the biennium 2008–2009 can be subsumed under the Programme budget 2008–2009.</p> <p>(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds) Not applicable.</p>
<p>4. Administrative implications</p> <p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant) All levels of the Organization.</p> <p>(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant) 3.5 staff members (full-time equivalent) across the six regional offices in order to build regional capacity to work with countries, in line with the resolution.</p> <p>(c) Time frames (indicate broad time frames for implementation) Three years (2009–2011), with a report on progress to be submitted to the Sixty-fifth World Health Assembly in 2012 in line with the resolution.</p>

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union and its 27 Member States, said that the Commission's work was important in understanding how to bring health to all. The Commission's report¹ identified the underlying causes and the actions needed in order to diminish those inequities. He supported the draft resolution and invited all countries to work together in finalizing an effective resolution. He also called for renewed leadership by WHO on health equality.

Dr ZARAMBA (Uganda), speaking on behalf of the Member States of the African Region, expressed support for the draft resolution. Social determinants greatly affected the health status of a nation, and greater knowledge was needed about how they influenced individual and community health. Social determinants differed considerably both between and within countries in the African Region, along with inequalities in health status, well-being and social practices.

¹ See Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health*. Geneva, World Health Organization, 2008.

The evidence gathered by the Commission on Social Determinants of Health would guide Member States and the Secretariat in their efforts to overcome health inequalities. Unless the social determinants of health were addressed, many disease-specific targets, including the health-related Millennium Development Goals, would never be achieved. He appreciated the three main recommendations and the action areas identified in the Commission's report.

More technical and financial support would be needed to assist the Member States of the Region to implement the Commission's recommendations. Lack of reliable data was a challenge. Health inequity must be measurable both within countries and across the world. National governments and international organizations such as WHO and ILO should set up surveillance systems for national and global health equity, monitor social determinants of health and evaluate the impact of policies. National governments must commit themselves, with the support of international partners, to clearly defined policies for multisectoral social protection.

The poor performance of many economies in the African Region presented a further challenge. The assurances and commitments of donor countries, at the high-level consultation on the financial crises and global health held that week, were gratifying. African Member States needed more support in strengthening leadership and governance at all levels and in addressing the findings and recommendations generated by health equity analysis.

Dr JAYANTHA (alternate to Mr de Silva, Sri Lanka), endorsing the draft resolution, said that health inequities were associated with social, economic, cultural and political factors. He welcomed the Commission's final report; its key findings should be taken into consideration by the Member States in the formulation of public policy. Health care in Sri Lanka was based on primary health care and recognized the influence of social determinants of health. Political commitment had been shown by the provision of free health care for all citizens, and by free education at all levels, in order to maximize social justice. As a result, the country had achieved a high literacy rate and commendable health indicators.

Sri Lanka would continue to play a key role in WHO's work on the social determinants of health. In February 2009, his Government would host a high-level consultation for countries of the South-East Asia Region in order to discuss the Commission's recommendations. The meeting should encourage a healthy debate which would benefit other regions as well.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland), said that, at the launch of the Commission's report in London in November 2008, his Prime Minister had stated that it was a matter of social justice to redress the inequality in life expectancy between countries. Furthermore, a major review of health inequalities in England would be undertaken. In September, his Government had contributed to a US\$ 16 000 million deal to restore progress towards meeting the Millennium Development Goals. Global financial problems increased the need for action: they should not be seen as a reason to delay. The draft resolution, of which the United Kingdom was a sponsor, proposed ways of tackling health inequalities collectively.

Dr VOLJČ (Slovenia), speaking as a sponsor of the draft resolution, said that the social determinants of health were closely related to the Millennium Development Goals, WHO's work on communicable and noncommunicable diseases, and the financial crisis. They were more influenced by political, economic and legislative circumstances than by health care itself. In many cases, for example, recent epidemics or the eradication of poliomyelitis, public health workers knew what should be done, but lacked the necessary support. Economic growth by itself did not reduce inequity: social inequities had increased between and within countries and regions even in the recent era of strong economic growth.

In the past, the health sector had targeted the immediate causes of ill-health and relied solely on its own capacities. Health determinants must be approached in collaboration with other sectors. In a less developed region of Slovenia, with the support of the WHO European Centre for Investment for

Health and Development and with local participation, health issues and health standards had been incorporated in the tourism, agriculture, transport, education and social sectors.

Health inequities could not be successfully confronted without a comprehensive “health for all policies” approach. Involving other sectors must be carefully planned, take into account sectoral motives and potential, and receive monitoring support.

Mr HOHMAN (alternative to Dr Wright, United States of America) welcomed the Commission’s report and the draft resolution. His Government was interested in examining the social and economic factors affecting health outcomes. The President had spoken of the need to address economic inequities and health disparities, possibly through support for national commissions or a global conference. The Commission’s report added to the existing data showing how social factors, such as income inequalities or lack of education, could worsen health. However, what most Member States lacked was not information but resources. The report’s recommendation that countries should establish universal social protection programmes was based on data from developed countries, and from the more successful developing countries. That approach might help other countries to build the political will and mobilize the resources needed for the programmes in question.

The Secretariat should provide Member States with evidence on which policy-makers could base decisions and with technical support for their implementation. He endorsed the Commission’s proposals for improving data collection in countries and enhancing WHO’s technical capabilities to assess evidence relating to social and environmental factors that influenced health.

Dr JAKSONS (Latvia) proposed that the draft resolution should be amended to emphasize the need for health ministries to play a stewardship role, as advocated in the Tallinn Charter: Health Systems for Health and Wealth, adopted at the WHO European Ministerial Conference on Health Systems, in June 2008.

Dr GOPEE (Mauritius) said that, like other small island developing States, Mauritius had some vulnerabilities, but it had achieved comparatively good health indicators: major infectious diseases had been largely controlled and nearly 100% vaccination coverage achieved. However, noncommunicable diseases, particularly diabetes, were a major problem.

Democracy had ensured political stability in Mauritius; health care was free from the primary to the tertiary levels; and education was compulsory and also free up to the tertiary level. Social and medical care for the elderly, women’s rights, and child welfare had always been high priorities.

Since independence in 1968, Mauritius had made a strategic move from economic dependence on sugar production to manufacturing and tourism. The resulting development of infrastructure had enhanced the country’s health conditions; generated employment; improved working and living conditions; and ensured nutrition and food security. That experience could inspire other Member States.

Dr BUSS (Brazil) paid tribute to the late Dr Lee Jong-wook, former Director-General of WHO, for having established the Commission on Social Determinants of Health and thanked the Commission for its report.

He expressed support for the draft resolution. Inequities in health between countries, or within countries, were morally unacceptable. He proposed that, in addition to the global event mentioned in subparagraph 4(j) of the draft resolution, the Director-General should be asked to convene a global conference on social determinants of health, in 2010 or 2011, in order to raise awareness and assess the work accomplished following the adoption of the draft resolution currently before the Board, exchange experiences and identify the best strategies for action. Such a conference should be organized in collaboration with Member States and other United Nations agencies.

Brazil’s national commission on social determinants of health had highlighted effective social protection policies, such as the primary health-care policy and the allocation of family allowances to

the poor. Several changes had been proposed to national policies, including the linkage of social protection and economic policies.

Various mechanisms had been established in his Region in order to promote discussion, and disseminate policies and technical practices, including a network for the exchange of experiences and methodologies.

(For resumption of the discussion, see below.)

Discussion of the health situation in the Gaza Strip: Item 4.16 of the Agenda (Document EB124/35)
(continued from the third meeting)

The CHAIRMAN drew attention to a revised version of the draft resolution entitled “The grave health situation caused by Israeli military operations in the occupied Palestinian territory, particularly in the occupied Gaza Strip”, incorporating amendments proposed by Members, which read:

The Executive Board,

Guided by the principles and objectives of the Charter of the United Nations, the Constitution of WHO, international law and international humanitarian law and the Universal Declaration of Human Rights;

Affirming that all human rights are interdependent and complementary and that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Confirming ~~Reiterating~~ the applicability of the Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War, of 12 August 1949, to the occupied Palestinian territory;

Referring to the reports and statements issued by the World Health Organization, the International Committee of the Red Cross and Red Crescent Societies, ~~and~~ the United Nations Relief and Works Agency, the United Nations Office for the Coordination of Humanitarian Affairs, ~~and~~ the United Nations Children’s Fund and other international and regional organizations, relating to the deteriorating health and humanitarian situation in the occupied Gaza Strip as a result of Israeli military operations;

Recognizing also that the Israeli **blockade siege** imposed on the occupied Gaza Strip and prevention of the passage and delivery of humanitarian supplies of medicines, food and fuel will lead to grave health and humanitarian consequences;

Expressing its deep concern regarding the consequences of Israeli military operations in the occupied Gaza Strip, which have, thus far, resulted in the killing of more than 1300 persons and injured thousands of Palestinian civilians, more than half of whom are women, children, infants and elderly persons;

Expressing its deep concern about the serious deterioration of the health conditions of all Palestinians in the occupied Palestinian territory and in the Gaza Strip in particular;

Asserting the right of patients as well as Palestinian and other medical personnel to access Palestinian health institutions,

1. WELCOMES and emphasizes the respect of the ceasefire from both parties and **calls on Israel for an immediate, durable and fully respected ceasefire leading to full withdrawal of Israeli forces from Gaza Strip, to lift its blockade** ~~calls for the withdrawal of Israeli military forces from the currently occupied Gaza Strip, the lifting of the siege, and to open the opening of all borders crossings~~ to allow access and free movement of humanitarian aid to the occupied Gaza Strip, including the immediate establishment of humanitarian corridors to ensure the delivery of humanitarian medical and food aid and **to facilitate the passage of medical teams and the transfer of the wounded and injured;**

2. CALLS for avoiding of targeting of hospitals, clinics, medical centres, ambulance and emergency crews and food and medicine warehouses;
3. STRESSES avoiding targeting civilians and residential areas in accordance with the Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War;
4. CALLS **upon** ~~for~~ providing Palestinian people with the protection ~~in order~~ to live **in security** ~~securely~~ on their land, allowing them free movement and ~~work~~, **facilitating** ~~facilitate~~ the tasks of medical teams, ~~and~~ ambulances; and emergency relief efforts, and enabling them to continue to provide health services;
5. CALLS for the urgent provision of necessary support for the Palestinian people **by** ~~in~~ making available the urgent and immediate needs of ambulances and medical teams, medicines and medical supplies, as well as necessary coordination measures to facilitate the passage of this assistance to the Gaza Strip in support of the health sector and preventing the collapse of health institutions;
6. CALLS for contribution to the reconstruction of the health infrastructure in the Gaza Strip, which has been destroyed by the Israeli military operations;
7. REQUESTS the Director-General to dispatch **an urgent specialized health mission** ~~a special mission~~ to identify the urgent health and humanitarian needs and assess the destruction **of medical facilities** that has occurred in the occupied Palestinian territory, particularly in the Gaza Strip and to submit a report on **current, medium- and long-term needs** on the direct and indirect effects of the Israeli military operations to the Sixty-second World Health Assembly.

The financial and administrative implications of the proposed resolution were:

1. Resolution The grave health situation caused by Israeli military operations in the occupied Palestinian territory, particularly the occupied Gaza Strip	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected results:
5. To reduce the health consequences of emergencies, disasters, crises and conflicts and minimize their size and economic impact.	5.2 Norms and standards developed, capacity built and technical support provided to Member States for a timely response to disasters associated with natural hazards and to conflict-related crises.
	5.3 Norms and standards developed, capacity built and technical support provided to Member States for assessing needs and for planning and implementing interventions during the transition and recovery phases of conflicts and disasters.
	5.6 Effective communications issued, partnerships formed and coordination developed with other organizations in the United Nations system, governments, local and international nongovernmental organizations, academic institutions and professional associations at the country, regional and global levels.

<p align="center">(Briefly indicate the linkage with expected results, indicators, targets, baseline)</p> <p>Linked with indicators 5.2.1, 5.3.2, 5.6.1 and 5.6.2.</p>
<p>3. Financial implications</p> <p>(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)</p> <ul style="list-style-type: none"> • US\$ 13.5 million for the acute response period • US\$ 22 million for the recovery and reconstruction phase • US\$ 2 million for the implementation of the health cluster. <p>(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)</p> <ul style="list-style-type: none"> • US\$ 18 million for the biennium 2008–2009 <p>Costs will be incurred primarily by the WHO Office in the occupied Palestinian territory, but also by the Regional Office for the Eastern Mediterranean and headquarters.</p> <p>(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009?</p> <ul style="list-style-type: none"> • US\$ 900 000 under existing programmed activities for the biennium 2008–2009. The rest will have to be added into the programme as resources become available from special appeals. <p>(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)</p> <p>Through a flash appeal for the Gaza Strip; the revised Consolidated Appeal for the occupied Palestinian Territory 2009; the European Commission's Humanitarian Aid department's contribution for strengthening WHO's work in emergencies.</p>
<p>4. Administrative implications</p> <p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)</p> <p>Headquarters, the Regional Office for the Eastern Mediterranean and the WHO Office for the occupied Palestinian territory in Jerusalem.</p> <p>(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile)</p> <ul style="list-style-type: none"> • One dedicated health cluster coordinator in the professional category for two years (at US\$ 156 000) • One dedicated deputy health cluster coordinator in the professional category for two years (at US\$ 376 000) • Assessment and response team deployed for three months (at US\$ 200 000) <p>(c) Time frames (indicate broad time frames for implementation)</p> <ul style="list-style-type: none"> • Special mission (two weeks) • Health cluster coordination (two years) • Response operations (three months) • Recovery and reconstruction (two years).

Dr ABDESSELEM (Tunisia) said that the sponsors of the draft resolution agreed that some changes to the wording needed to be made. He thanked the representative of the European Union for his positive stance, which had allowed agreement to be reached, and called for the Board to adopt the new version of the draft resolution by consensus.

Mr BURCI (Legal Counsel) stated that Egypt, Mali, Mauritius, Morocco, Niger, Sao Tome and Principe, Turkey and Uganda wished to join the list of sponsors of the draft resolution.

He drew attention to several amendments not included in the latest version of the draft resolution. In the fourth preambular paragraph, “Red Crescent Societies” should be replaced by “the International Federation of Red Cross and Red Crescent Societies”. In paragraph 1, “on Israel for an immediate, durable and fully respected ceasefire leading to full” should be replaced with “for a complete” and “immediate establishment” should be replaced with the word “reinforcing”. Paragraphs 2 and 3 should be merged to read “Stresses avoiding targeting civilians and residential areas from both sides in accordance with the Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War and avoiding of targeting of hospitals, clinics, medical centres, ambulance and emergency crews and food and medicine warehouses”, with the numbering of the paragraphs that followed changing as appropriate. In the final line of paragraph 7, the words “on health” should be inserted between the words “effects” and “of”.

Mr STORELLA (alternate to Dr Wright, United States of America) requested a roll-call vote on the draft resolution including the preceding oral amendments.

A vote was taken by roll-call, the names of the Member States being called in the French alphabetical order, starting with El Salvador, as determined by lot.

The result of the vote was as follows:

In favour: Afghanistan, Bangladesh, Brazil, China, Denmark, Djibouti, Hungary, Indonesia, Latvia, Mali, Mauritania, Mauritius, Niger, Oman, Paraguay, Peru, Republic of Korea, Republic of Moldova, Russian Federation, Sao Tome and Principe, Singapore, Slovenia, Sri Lanka, Tunisia, Turkey, Uganda, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland.

Against: United States of America.

Abstaining: Bahamas, Malawi, New Zealand, Samoa.

Absent: El Salvador.

The resolution, as amended, was therefore adopted by 28 votes to 1, with 4 abstentions.¹

Dr DAHL-REGIS (Bahamas), speaking in explanation of vote, said that she had had to abstain as she had not received voting instructions from her Government.

Mr STORELLA (alternate to Dr Wright, United States of America), speaking in explanation of vote, regretted that, despite general agreement about the importance of a response by WHO to the alarming situation in the Gaza Strip, the draft resolution could not be adopted by consensus. His Government had not been able to support the resolution because it believed that the Executive Board, as a global health body, did not have a mandate to make political judgements. He noted that he and others had requested reasonable time to review and amend the text so as to ensure that it was free from one-sided rhetoric. The United States of America supported immediate action to identify the humanitarian and health needs and to ensure that medical assistance and supplies were provided. It would do everything in its power to assist with post-ceasefire needs, and would engage in serious

¹ Resolution EB124.R4.

efforts to promote the stabilization and normalization of life for the people of the Gaza Strip, and to secure the longer-term prospects for peace.

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, said that the European Union would remain firmly committed to supporting the health and humanitarian activities of WHO in aid of the Palestinian population affected by the recent conflict in the Gaza Strip. The five Member States of the European Union represented by members of the Board had voted in favour of sending a specialized health mission to identify the most pressing needs, but regretted that there had not been a greater focus on health and humanitarian matters. The European Union welcomed the recent bilateral ceasefire, which must be durable and fully respected, and hoped that it would lead to a rapid alleviation of the suffering of the civilian population. All parties, especially Israel, must grant immediate, unhindered and safe passage for the delivery of essential services.

Dr ABDESSELEM (Tunisia), speaking on behalf of the sponsors, extended his sincere thanks to the members of the Board for supporting the resolution.

Commission on Social Determinants of Health: Item 4.6 of the agenda (Document EB124/9) (resumed)

Mr MIGUIL (Djibouti), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that a recent regional survey of social determinants of health had identified areas, largely the same as those mentioned in the report, in which action must be taken to overcome health inequities. For 20 years in his Region community-based initiatives had been striving to improve conditions in terms of nutrition, safe drinking water, sanitation, shelter and women's empowerment. Eastern Mediterranean countries were being encouraged to develop those initiatives into tools for action on social determinants of health. He cited examples of how the recommendations of the Commission were being implemented in his Region, notably through a "health in all policies" approach: a strategic plan developed in the Islamic Republic of Iran; urban regeneration in Cairo; and an intersectoral coordination approach in Yemen.

An instrument for monitoring health equity was being designed within the framework of the Eastern Mediterranean Regional Health Systems Observatory. The tool could be adapted to building a database for policy-makers at country level. A regional conference on the social determinants of health in 2009 would provide an opportunity to share experiences.

Ms ROCHE (New Zealand), emphasizing intersectoral action in steps to address the social determinants of health, said that her country's initiatives, which went beyond the health sector, had already helped to reduce ethnic inequalities in health. She welcomed the draft resolution and looked forward to global progress towards the goal of health for all through action on the social determinants of health.

Ms TOELUPE (Samoa) supported the recommendations contained in paragraphs 19, 20 and 21 of the report. Highlighting the influence of other sectors on health, she emphasized the key role of women at grass-roots level in tackling the social determinants of health. Community-based initiatives would help to strengthen primary health care and, thus, entire health systems.

Mr FISKER (Denmark) said that the Secretariat must acknowledge the request from Member States to prioritize, and allocate sufficient resources to, action on the underlying social determinants of health. Member States must assume their own responsibilities for that work, which called for close intersectoral cooperation. He supported the adoption of a substantial resolution on the topic. He proposed three amendments to the draft resolution: first, a new paragraph should be inserted after the sixth preambular paragraph reading: "Welcoming in this regard resolution WHA61.18, which initiated annual monitoring by the World Health Assembly of the achievement of the health-related Millennium

Development Goals”; secondly, another new paragraph should be inserted after the final preambular paragraph, reading: “Mindful of the fact that mental health is an integral part of health”; and thirdly, the word “objective” should be inserted before the word “indicators” in subparagraph 4(c).

Dr ADITAMA (alternate to Dr Supari, Indonesia) emphasized the strong links between poverty, which was the main social determinant of health, and the global economic system, determined by high-income countries, and which had widened the gap between high-income and low-income countries. Members of the Board and the Commission should consider how to promote a fairer system. Capitalism and liberalization had no place in national health systems. They endangered human life by, for example, treating medicines as commercial goods available only to those who could afford them; by encouraging brain drain of health personnel from low-income countries; and by allowing industries in rich countries to exploit natural resources in poor countries, without protecting the local population from the resulting health hazards, and misleadingly claiming to adhere to the concept of corporate social responsibility. The Commission should make strong recommendations on how to achieve health equity through alternative economic solutions.

Dr STARODUBOV (Russian Federation) acknowledged the results of the Commission’s productive and substantial investigations, carried out in the best traditions of social medicine. However, the Secretariat’s report and the Commission’s conclusions did not fully reflect the rich content of the latter’s report. Many of the factors underlying health inequities exceeded WHO’s mandate. He therefore supported the call for United Nations agencies to engage throughout the system in discussion of a strategy for countering health inequities.

He welcomed the Secretariat’s report and strategy for strengthening the potential of the Secretariat and Member States to monitor and address the social determinants of health. The report remained more than ever relevant against the backdrop of financial crisis. WHO could demonstrate its leadership role by involving the international community in the struggle against inequity.

Dr SERPAS MONTOYA (alternate to Dr Larios López, El Salvador) welcomed the report. The Commission’s recommendations covered the essential areas in which countries needed to work in order to address social determinants of health, such as: the development of surveillance systems for social determinants going beyond the health sector; the establishment of indicators and continuous evaluation; and the development of national health policies derived from broad agreement. Countries should gradually build up those indicators and tools. His country had adopted legislation aimed at involving health institutions in common efforts with health policy based on primary health care. He supported the proposed draft resolution.

Dr REN Minghui (China) supported the recommendations made by the Commission in its report, the Chinese version of which, when made available, would be given wide publicity in order to raise awareness of the social determinants of health. As the report pointed out, health equity was a reflection of society, and policy-making to address the issue was not limited to the health sector but rather encompassed all State affairs. His Government had developed slogans and goals for building a basic health system covering both urban and rural areas and providing safe, practical and affordable services. In the light of the Commission’s recommendations, the Secretariat should assist Member States to implement health-for-all policies that addressed social determinants; and in setting up surveillance and evaluation systems, incentives for countries to make real progress towards health equity. His Government supported the main lines of the draft resolution. However, the text failed to reflect all the opinions put forward or the role played by civil society. The wording of subparagraphs 3(a), (b) and (c) in that respect was unclear. In subparagraph 4(j), the word “prepare” (a global event) might perhaps be replaced by “organize”, and the meaning of “global event” should be clarified.

Dr MOHAMED (Oman) said that paragraph 2 of the report contained no mention of individual behaviour as one of the social determinants with serious repercussions on health, and that the omission should be rectified. For example, contracting HIV infection was the result of individual actions. Mention should also be made of human development indicators, child development indicators and women's development indicators, all of which had to be addressed in order to achieve the objectives outlined in paragraphs 19 to 21 of the report. He emphasized that in the context of multisectoral policies, account should be taken of primary health care in order to ensure health equity and social equality.

Dr GIMÉNEZ CABALLERO (Paraguay) congratulated the Commission on its recommendations. The conclusions provided an ethical imperative for reformulating public health policies, an expression of solidarity for concrete action to fill the gaps that had left millions in morally unacceptable conditions. WHO should set up mechanisms for continuous monitoring of the reduction of such gaps, in both the WHO regions and countries. His country was a sponsor of the draft resolution and he endorsed the proposal by Brazil to convene a world conference on social determinants of health.

Dr STARODUBOV (Russian Federation) joined the member for China in calling for the Commission's report to be issued in all official languages. So many positive assessments had only increased his desire to see it in Russian.

Dr SADRIZADEH (Islamic Republic of Iran)¹ said that the social determinants of health accounted for the bulk of health inequities both within and between countries. Global solidarity, high-level political commitment and intersectoral coordination was required. WHO should act as a catalyst in putting the social determinants of health high on the agenda. His Government was committed to reducing health inequities and wished to sponsor the draft resolution. It had encouraged the Asian Parliamentary Assembly to adopt a resolution urging member parliaments to promote policies on health equity and strengthen collaboration among themselves. A subcommittee had been set up to identify the main social determinants of health inequities and provide relevant recommendations.

Dr THAKSAPHON THAMARANGSI (Thailand)¹ said that his Government appreciated the work of the Commission. Closing the gap of health inequalities would require political will worldwide and significant changes in global governance. The aggressive marketing of junk food and soft drinks continued, and the obesity rate among adults in the United States, for example, stood at 34%. The draft resolution would be crucial for applying the Commission's recommendations. However, the call it made for market responsibility was so weak that it was unlikely to be heard by industry unless the world developed better global governance mechanisms and national actions to root out structural inequity and the determinants of poor health. Key terms relating to equity were misused. For example, the phrase "health inequalities", used throughout the text, should be replaced by "health inequities". Some health inequities were attributable to biological variations, others to the external environment and conditions beyond the control of individuals. In the former case it might be impossible to change health determinants, and health inequities were therefore unavoidable. In the latter, uneven distribution was avoidable and therefore unjust, resulting in health inequities.

The draft resolution did not adequately reflect the three main recommendations made by the Commission: improving daily living conditions; tackling inequitable distribution of power, money and resources; and measuring and understanding the problem and assessing the impact of actions. Paragraph 3 should be redrafted to reflect those recommendations. Paragraph 2 should cover the

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

notion of global good governance, market responsibilities in tackling inequitable distribution, ensuring health equity in policies and taking into account the voice of the population, especially the poor. Paragraph 4 should request the Director-General to work with the international community to ensure health equity in policies, systems and programmes, and should refer to the provision of technical support to Member States in monitoring, research and training on social determinants of health. He suggested a major revision of the text. The recommendations made in the Commission's report must be translated into a clear and forceful draft resolution, and the version before the Board was unacceptable. He agreed with other speakers that a working group might be needed to improve the draft resolution. Thailand was ready to take part in such action.

The CHAIRMAN said that any proposals by the representative of Thailand, a Member State not represented by a member of the Board, had to be supported by one of the Board's members in order to be considered.

Professor HAQUE (Bangladesh) supported the proposals made by the representative of Thailand.

Mr CAVALERI (Argentina)¹ welcomed the report and expressed support for the draft resolution. Overcoming health inequities was a high priority of his Government. In cooperation with PAHO, Buenos Aires would host, in August 2009, the first world fair of healthy municipalities, cities and communities. The fair would promote the healthy cities initiative; primary health care; regional and national initiatives to achieve the Millennium Development Goals; and exchange of good practices regarding successful local development. Some 2000 participants were expected, representing a wide range of institutions.

Dr MUÑOZ (Chile)¹ said that, since unequal access to power and goods was a major risk factor for health, the search for greater equity in countries had been transformed from a philosophical discussion into an obligation. Chile had embraced the idea of reducing inequalities. It supported the draft resolution and wished to become a sponsor. The draft resolution should, however, emphasize that advocacy was needed with respect to decision-makers at all levels. The concerns expressed by the Commission must not be seen by ministers of finance and national leaders as confined to health officials: they were integral to the brief of all who sought to improve the population's living conditions. He advocated social protection systems that operated in consonance with social determinants of health, covering all sectors with responsibility for people's living conditions.

(For continuation of the discussion, see summary record of the sixth meeting, section 2.)

The meeting rose at 15:30.

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