

SIXTH MEETING

Thursday, 22 January 2009, at 09:15

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

1. PROGRAMME AND BUDGET MATTERS: Item 5 of the Agenda

Programme budget 2006–2007: performance assessment: Item 5.1 of the Agenda (Documents PBPA/2006–2007 and EB124/19)

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board and recalling the Committee's deliberations as set out in section 3.1 of document EB124/3, said that the Committee had welcomed the report on performance assessment and expressed appreciation for its utility and comprehensiveness. However, in the light of the relatively low level of implementation in 2006–2007, Committee members had encouraged the Secretariat to improve the Organization's implementation rates. Some members had noted that where expected results had not been fully achieved, it would have been useful to give greater detail on the reasons. Such assessment findings should be made available in good time for governing body discussions on programme budgets.

The Committee had endorsed the proposal to change the time frames for, and format of, monitoring and assessment of the Programme budget 2008–2009, thereby allowing for presentation by the Secretariat of a summary mid-term review to the Committee at its tenth meeting and to the Executive Board at its 125th session in May 2009, as well as production of a summary programme budget performance report in May 2010.

Dr AHMADZAI (Afghanistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, commended the transparent and balanced report, which revealed the progress made in strengthening of health systems, access to medicines, the growing number of persons affected by HIV/AIDS, tuberculosis and malaria, new and emerging diseases, and emergency response.

There was still room for further improvement in performance assessment, particularly with regard to performance indicators, which should be more precise, measureable and relevant.

Observing that the biennium 2006–2007 had seen a record level of expenditure, he pointed out that financial implementation had not kept pace with the budgetary growth of the Organization. The regular budget would have to grow considerably faster in order to align funding and programme delivery, which would improve predictability of resource availability and improve implementation capacity.

Mr AITKEN (Assistant Director-General) agreed that the work on performance assessment needed to be furthered and improved, with particular focus on the indicators.

Ms JAQUEZ (Mexico),¹ speaking on behalf of the Member States in Latin America, referred to the recent Intergovernmental Meeting on Pandemic Influenza Preparedness, the changed date and venue of which had entailed extra cost to the Organization. Expressing gratitude to the Secretariat for keeping the increased costs low, she asked how those costs would be covered. Such a change of date

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

and venue should not set a precedent for future work of any negotiating bodies established by the Organization.

The DIRECTOR-GENERAL recalled that the meeting in question had had to be postponed because of the unavailability of the Chair. The Secretariat and the officers of the Meeting had discussed the only two solutions: the first, to select a new Chair from among the members of the Bureau, which option had been firmly resisted both by the officers and among the Member States on account of the excellence of the chairmanship of Ms Jane Halton of Australia and the need for continuity. The alternative had been to change the date, and consequently the venue, of the meeting, which had entailed additional costs to the Organization of some US\$ 80 000. It had been an unfortunate occurrence, but the Secretariat was in the hands of the officers of the Meeting and Member States.

The CHAIR took it that the Executive Board wished to take note of the performance assessment reports on the programme budget 2006–2007.

It was so agreed.

Medium-term strategic plan 2008–2013 and Proposed programme budget 2010–2011: Item 5.2 of the Agenda (Documents MTSP/2008–2013 (Amended (draft)), PPB/2010–2011 and EB124/20)

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, recalled that, in its discussion of the draft amended Medium-term strategic plan 2008–2013 and the draft Proposed programme budget 2010–2011, the Committee had expressed appreciation for the clarity of the documents and welcomed the innovation of dividing the draft Proposed programme budget 2010–2011 into three segments: WHO programmes; outbreak and crisis response; and partnerships and collaborative arrangements, since that grouping of items enhanced transparency.

The Committee had welcomed the development of the core voluntary contributions account but expressed concerns at the growing imbalance between assessed and voluntary contributions; the consequent increasing reliance on earmarked voluntary contributions; the inequitable distribution of budget funds to certain strategic objectives; and the uneven distribution of the budget across geographical regions.

Some members of the Committee had expressed concern about the ability of the Organization to raise sufficient income in the current economic climate, and to implement fully the Proposed programme budget 2010–2011; others had called for more budgetary discipline and realism. Some members had requested clarification on the draft Proposed programme budget, including projections of expected exchange rate fluctuations, before the document was submitted to the Sixty-second World Health Assembly.

The Committee had stressed the importance of improving implementation and had recommended a review of the overall level of the Proposed programme budget. Other issues discussed had included: the establishment of a revolving fund in order to allow for more predictable funding of emergency response operations; the need to limit the carry-over from one biennium to the next; and the proposed reallocation of assessed contributions in order to cover the shortfall in resources for strategic objectives 12 and 13. The Committee recommended that the Executive Board should take note of its deliberations set out in paragraph 3.3 of document EB124/3.

The CHAIRMAN, opening the floor for general comments, observed that the Director-General would take such comments into account in any revision of the budget that she might make before its presentation to the Sixty-second World Health Assembly.

Dr MOHAMED (Oman), speaking on behalf of the Member States of the Eastern Mediterranean Region, supported the draft Proposed programme budget 2010–2011 with its enhanced transparency and the amended Medium-term strategic plan 2008–2013, in particular the inclusion of climate change and other important subjects. He welcomed the plans for interventions in the event of epidemics and crises. He noted increased expenditure relative to the previous budget and the need for increased funding.

The lack of flexibility could hamper certain programmes. The regular contributions represented 17% of the budget, with the rest coming from other contributions. Greater flexibility was needed so that resources were not subject to conditions or limited to certain expenditures. In a financial crisis, health and health services were easy targets for cuts. His country was still trying to recover from cuts in the budget for housing and health from previous years. Earmarked voluntary contributions were not generally devoted to the problems of developing countries. The Organization should be given the flexibility to devote its resources to urgent issues and should be present in all countries.

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union and its 27 Member States, said that the European Union had read with interest the draft Proposed programme budget 2010–2011 and the amended draft Medium-term strategic plan 2008–2013 and welcomed the clarifications.

The division of the draft Proposed programme budget into three categories had enhanced clarity and transparency. However, he questioned whether WHO had sufficient implementation capacity to handle the proposed increase, relative to the previous biennium, of more than US\$ 1000 million. The accumulated surplus carry-over of 40% required further explanation.

The issue was related to the earmarking of contributions. High levels of earmarking undermined the ability of the Board to guide the Organization effectively. Important policy decisions of the Health Assembly appeared to have been disconnected from the financing of the Organization. Moreover, partnerships offered opportunities to improve global health but raised problems of earmarking, governance and duplication. The European Union welcomed the Secretariat's proposal and the guidelines but the issue required further discussion, especially on the role of partnerships in the financing of core activities. Although increased voluntary contributions were welcome, support costs should be covered, and extrabudgetary funds directed to WHO's priorities and controlled by the governing bodies. In regard to the regular budget, zero nominal growth, as an approach, should be continued; and the Secretariat should consider how exchange-rate fluctuations might be counterbalanced by savings. Noting that communicable diseases constituted nearly half the budget, he looked forward to a revised proposal with a better balance between resources and the global health burden and Millennium Development Goals, with more precise information on staff costs and their evolution for each strategic objective.

Tobacco control needed close coordination between WHO's Secretariat and the Convention Secretariat in order to avoid duplication and to use resources efficiently.

The European Union looked forward to continued cooperation with WHO on budgetary matters. It welcomed the decision by the Programme, Budget and Administration Committee to set up an independent expert oversight committee and was willing to help to define its terms of reference. Regarding the Global Management System, the European Union urged the Secretariat to overcome the problems. The System was already offering more transparent data and should prove its worth in time.

Professor HAQUE (Bangladesh) commended the draft amended medium-term plan. The achievement of the Millennium Development Goals depended on the coordinated teamwork of WHO at all levels. His Government was committed to those goals and much remained to be done.

Mr FISKER (Denmark) welcomed WHO's acknowledgement that the time had come to consolidate growth and strengthen implementation capacity. Rapidly growing budgets, insufficient implementation capacity and major transfers of funds from one biennium to the next formed an injudicious combination. The changing ratio between regular and voluntary contributions was a

sensitive issue, as few Member States wished to increase their regular contributions. The aim should be not so much to obtain more funds, rather to have funds that were more secure and flexible.

Denmark welcomed the new structure of the budget, which improved transparency. Partnerships accounted for 20% of the total budget, which raised questions of governance and accountability. Perhaps the share of partnerships in the total budget should be limited in order to use the funds already available. The adoption of the action plan for the global strategy for the prevention and control of noncommunicable diseases had been followed by increased resources; that example reflected changing priorities with the shifting burden of disease. Such an approach should be continued so as to reach a balance between communicable and noncommunicable diseases.

Ms ROCHE (New Zealand) commended the report and the Secretariat's work on indicators. However, the amount of carry-over, both in absolute terms and as a proportion of the total budget, was a matter of concern. She supported the views of the European Union on the management of carry-over while ensuring effective expenditure of the proposed increase in the biennial budget. She asked how such factors would influence budget planning for the following biennium. Improved implementation should reduce future amounts of carry-over. In regard to strategic objective 4, she welcomed the Secretariat's offer to review the allocation. Reduced funding for that objective was inconsistent with achievement of the Millennium Development Goals, which should be WHO's top priority. As for strategic objective 6, New Zealand supported the view of the European Union on the need to avoid duplication of work on tobacco control between the WHO's Secretariat and the Convention Secretariat. She was pleased with the improved coordination between the two. The former should be supporting the implementation of the Convention in the countries that were Parties and encouraging others to ratify it. She looked forward to the report on the establishment and operation of an independent audit.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) welcomed the introduction of new indicators for climate change and patient safety. In regard to strategic objective 3 he supported the increased resources for chronic disease, which better reflected the global burden. However, funding remained at 3% of the biennium budget whereas noncommunicable disease accounted for around 60% of all deaths. Regarding strategic objective 4, he shared the previous speaker's concern at the reduced funding and was grateful for the Secretariat's review of the allocation. Despite the financial crisis, it was certainly not the moment to reduce funding for health. Following the points made by the Programme, Budget and Administration Committee about implementation, the Secretariat should reexamine the budget. The problems of the Global Management System were a source of deep concern and had badly constrained the implementation process. However, the Director-General and her team were striving to resolve them.

Ms BLACKWOOD (alternate to Dr Wright, United States of America) welcomed the Proposed programme budget 2010–2011, which reflected a significant increase while consolidating growth and strengthening implementation capacity. She asked for indications of the implementation level for the Programme budget 2008–2009 and, if it were less than targeted, whether the Secretariat would make adjustments to the final budget level for 2010–2011. She supported the creation of an account for core voluntary contributions in order to manage resources effectively, but expressed concern about the reliance on regular funds to subsidize the administrative overheads of programmes funded by voluntary contributions. WHO should pursue a policy of cost recovery for extrabudgetary contributions.

In regard to miscellaneous income, she welcomed the Secretariat's commitment to realistic projections on exchange rates. The United States appreciated WHO's efforts to consolidate the increase in the core budget; it continued to advocate budgetary discipline, efficiency in implementation and programme prioritization.

Dr KAMOTO (Malawi), speaking on behalf of the Member States of the African Region, commended the Committee's report. The Region noted with concern the inadequate funding levels for: strategic objectives 4, relating inter alia to maternal and child health; strategic objective 7 on social and economic determinants of health; and strategic objective 9, related to nutrition and food security and crucial to the attainment of the Millennium Development Goals in Africa. It was gratifying that the Secretariat would review those and adjust the 2010–2011 budget accordingly before its submission to the Sixty-second World Health Assembly.

He commended the Secretariat's efforts to implement the Global Management System, to resolve the problems encountered, and to make contingency plans against future unfavourable developments. He welcomed the transparency of the Programme budget, the checks and balances and the proposal to set up an independent advisory committee, as that would improve accountability at WHO.

Professor AYDIN (Turkey) echoed previous speakers in emphasizing close cooperation between the Convention Secretariat and WHO's Tobacco Free Initiative in order to avoid duplication, given the scarcity of resources for tobacco control.

Mr TOURÉ (Mali), welcoming the Proposed programme budget, stressed Millennium Development Goals 4 and 5 relating to reducing child mortality and improving maternal health; the fight against epidemic diseases that particularly affected Africa; and accelerated efforts to eradicate poliomyelitis. The high risk of transmission of poliovirus in one country in Africa currently threatened those efforts.

Dr JAYANTHA (alternate to Mr de Silva, Sri Lanka) urged the Board to allocate more resources to the changing disease burden in Sri Lanka and many other countries, and mainly characterized by an increase in noncommunicable diseases.

Ms MASTAU (South Africa)¹ welcomed the cooperation between the Convention Secretariat and WHO's Tobacco Free Initiative, in relation to strategic objective 6 and to implementation of the guidelines and protocols of the Conference of the Parties. She asked what percentage of the budget had been allocated to gender support under strategic objective 6. She urged that the share of funding allocated to strategic objectives 7 and 9 should be increased, emphasizing the related health outcomes and the Millennium Development Goals. Expressing deep concern at the reduced resources allocated to strategic objective 4, and the related commitment to maternal health, she asked about the impact of that reduction and the reallocation of those funds.

Mrs NYAGURA (Zimbabwe)¹ echoed the concerns expressed with regard to the budget allocations for strategic objectives 4, 7 and 9, which were crucial to attaining the Millennium Development Goals. She appealed to donor countries to maintain flexibility and predictability of resources and enable the Director-General to respond to health priorities, particularly in the African Region.

Mr BLAIS (Canada)¹ reaffirmed his country's commitment to a policy of zero nominal growth in the budgets of international organizations. The complexity of the Proposed programme budget 2010–2011 encouraged further deliberation on the application of that policy, particularly regarding the balance between assessed and voluntary contributions, and to decisions on reductions. His country would share with others its experience and approach to zero nominal growth.

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

Mr PLATTNER (Switzerland),¹ acknowledging the budgetary difficulties the Organization faced as a result of the imbalance between assessed and voluntary contributions, announced that Switzerland would make its voluntary contributions more flexible for a period of three years. He encouraged the Secretariat to pursue fully flexible voluntary contributions.

Drawing attention to strategic objectives 12 and 13, particularly with regard to the capital master plan, he urged all international organizations to allocate an adequate percentage of their regular budget to infrastructure and equipment; he expressed regret that previous underfunding had been continued in the Proposed budget for 2010–2011, with potentially damaging consequences for both WHO's headquarters in Geneva and its regional offices. He urged the Secretariat to implement measures to comply with the Minimum Operational Security Standards of the United Nations.

Mr ITAYA (Japan)¹ emphasized that the allocation of funds should be examined carefully in the light of the financial crisis and changing health issues worldwide. Japan favoured a policy of zero nominal growth and urged additional measures to minimize the budget and maximize cost-efficiency, without sacrificing prioritized core objectives.

He urged the Organization to focus on its core mission and encourage newer players to share the overall burden. Transparency was critical to donor confidence, as was convincing taxpayers of streamlined operations, avoiding duplication and reduced costs. Knowing the measures taken and results achieved would enable Member States to advocate for a well-funded WHO.

Expressing doubt about the wisdom of applying a fixed currency adjustment mechanism, he asked how the Secretariat would protect itself against unfavourable currency fluctuations; and how would unexpected gains from favourable currency fluctuations be returned responsibly.

He endorsed the comments made by the member for Hungary and other speakers regarding partnership, the Global Management System and programme support costs. The roles and resources of WHO programmes and those of partnerships hosted by WHO needed to be clearly distinguished. Problems with the Global Management System, in which significant resources had been invested, must be resolved. His country was committed to a strong and fully-funded WHO: efficient, transparent and working in the best interests of all Member States.

Mr AITKEN (Assistant Director-General), responding to points made, stressed the need for more flexible and predictable funding. Pledges for a period of more than one or two years would give managers more room for manoeuvre, particularly in the first six months of a biennium. That would also make carry-over from the previous biennium, which currently accounted for around 25% of the budget, more manageable. Managing core voluntary contributions, which accounted for a very small percentage of voluntary contributions overall, was a constant challenge. Although the Secretariat had a clear idea of how they should ideally be allocated, budget aspirations were often not compatible with funding realities.

Concern had been expressed about reduced funding for strategic objective 4. However, a reallocation from strategic objective 4 to strategic objective 10, which dealt with the strengthening of health services, would benefit efforts to reduce morbidity and mortality at key stages of life; integration between the two objectives would thus be improved.

Work was continuing to solve the serious problems experienced with the Global Management System. Nevertheless, those had not been a significant cause of lack of implementation, which was attributable to a combination of factors. In fact, the System had made it possible to provide the expenditures in 2008 with greater timeliness. A forecast for miscellaneous income for 2010–2011 would also be prepared.

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The capital master plan had not yet been fully funded because Member States as a whole had not yet agreed to do so. Work therefore focused on regular maintenance to ensure that buildings and equipment continued to run rather than on any major new projects. Security was a top priority in high-risk areas but Member States had not yet been persuaded to provide the funding necessary for full implementation of the Minimum Operational Security Standards of the United Nations.

With regard to the problems of currency fluctuations, he explained that some measures had been taken but that there was a limit to what could be done. The impact of fluctuations would be calculated and reported to the Health Assembly, which could then decide how to proceed. In the meantime, the Secretariat was being encouraged to make savings in areas such as travel, publications and meetings.

The DIRECTOR-GENERAL thanked Board members for their comments, which, together with those from the Programme, Budget and Administration Committee, would guide her in revising the Proposed programme budget 2010–2011 before its submission to the forthcoming Health Assembly.

The discussion had been notable for its quality and honesty. She welcomed the call made by Japan and others for committed funding to ensure a strong WHO. She would heed concerns raised about budget discipline, the Organization's growth and ability to implement programmes, governance and the need to avoid duplication within the Secretariat and in WHO's relations with its partners. However, she could not act alone; she would need support from all Member States. For example, it had not proved possible to achieve the desired cost recovery through the levy for programme support costs, which was designed to avoid the use of assessed contributions to subsidize programmes financed by voluntary contributions. Ministries of finance and other donors often tried to negotiate the 13% levy downwards and the average achieved to date was 7%. Health ministries should strongly discourage such action.

She expressed concern that, although levels of voluntary contributions were commendably high, many donations were earmarked to an extent that skewed the core functions of the Organization. If Member States wished to heighten levels of security in WHO offices in high-risk areas, they and the Secretariat would need to examine the updating and funding of the Capital Master Plan.

In respect of cooperation between the Secretariat and the Conference of the Parties to the WHO Framework Convention on Tobacco Control, she was pleased to report progress towards joint planning.

The establishment of the Global Management System had proved a painful exercise to date, and one that had caused her much anxiety. Dr Lee Jong-wook had envisaged the institution of a modern integrated management system, the first in the United Nations system, that would enhance detail and transparency. Feedback from headquarters and the Western Pacific Region, the two areas where the new system had so far been implemented, indicated that progress was being made. However, patience would be needed and it was not possible to say how long it would take for the system to be fully functional across the whole Organization.

As indicated to the Programme, Budget and Administration Committee, she would convene a meeting of donors and other interested parties to consider how best to modernize WHO's funding over the medium to long term to ensure that the Organization had a business model that was fit for the twenty-first century. Again support from Member States would be crucial.

The CHAIRMAN, in the absence of further comments, took it that the Board had concluded its consideration of item 5.

It was so agreed.

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

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

Ms ALARCÓN (Colombia)¹ welcomed the proposal by the Commission on the Social Determinants of Health that there should be an integrated and uniform approach to efforts to attain the health-related Millennium Development Goals. Pragmatic and effective activities should be formulated, responding to countries' needs and priorities in social development. Colombia's national development plan for 2006–2010 had integrated poverty elimination, social protection, employment, health and education programmes. It aimed to reduce inequalities by emphasizing the most vulnerable population groups and regions, using the family as the entry point for care. Those activities had complemented social security and public health. Positive results were exemplified by the 94% immunization coverage of children in 2007.

Dr MOHAMED (Oman) supported the views expressed at the previous meeting by the representative of the Islamic Republic of Iran. Oman also wished to sponsor of the draft resolution.

Ms BILLINGS (Canada)¹ said that her country had participated in the work of the Commission. She commended the reports of the Commission and the Secretariat. Governments, organizations and academic institutions were increasingly considering initiatives that included the social determinants of health, important for addressing health inequities among vulnerable populations and timely, given the recent economic downturn. Canada was working with other countries to revise the draft resolution, of which it wished to be a sponsor.

Dr SEYER (World Medical Association), speaking at the invitation of the CHAIRMAN and on behalf of the World Medical Association, the International Council of Nurses, the International Pharmaceutical Federation and the World Dental Federation, which together formed the World Health Professions Alliance, welcomed the reports of the Commission and the Secretariat. The Alliance supported the holistic approach to social determinants of health. Health systems should emphasize universal coverage and quality of services. Primary health care must integrate referral systems, including secondary and tertiary care, and not become a second-class service used only by the poorest population groups. Access to health care should be the right of all. She also welcomed the recommendations for increased investment in health personnel. Disaggregated data would enhance understanding of women's contribution to formal and informal health systems.

More attention should have been given to the role of health professionals in addressing the social determinants of health and to the inequalities they faced in their daily work. Their unique experience should be considered in future reports.

The 2008 Joint Health Professions Statement on Task Shifting indicated that health professionals were having to deal with restricted resources. While the Alliance recognized the potential benefits of community health workers, the Statement warned that the new cadres of workers and shifting of tasks resulted in fragmentation and inefficiencies in health services.

Unhealthy and unproductive environments in health care adversely affected the recruitment and retention of health personnel; performance and cost-effectiveness; and patient outcomes. She called on Member States to support the Alliance's campaign to change the health-care workplace and advance the quality of health services.

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

Professor RANTANEN (International Commission on Occupational Health), speaking at the invitation of the CHAIRMAN, expressed satisfaction that the Commission had addressed material health hazards affecting the global workforce, which included biological agents and radio frequency fields. He emphasized further action and prevention management. Cardiovascular morbidity and mortality, metabolic syndrome and mental health were all rising as a result of increased stress related to work. The overall health of workers could improve through the strengthening of occupational health research and services, and the training of service providers.

He encouraged WHO to regard work-related social determinants of health as part of its programme for action. WHO should promote research on models for occupational health services that could respond to the new risks faced by workers worldwide. Resolution WHA60.26 encouraged all countries to implement comprehensive, occupational health services, so that occupational health could become a positive social determinant of health. His organization would collaborate with WHO and its partners in that aim.

Ms SHASHIKANT (Churches' Action for Health), speaking at the invitation of the CHAIRMAN, urged Member States to adopt the recommendations contained in the Commission's report. The Commission should act as a coordinating body in order to monitor implementation of the recommendations. The Secretariat should provide support to Member States for implementation and encourage the use of multilateral trade agreements. An intergovernmental working group should be created in which the views of civil society and social movements were represented. The social determinants of health and equity should be a priority of WHO and the international community.

Dr EVANS (Assistant Director-General) said that health equity was a powerful reflection of social justice. All partners, including civil society, should be actively engaged, empowered and included in addressing the social determinants of health. Evaluation and evidence were vital to measuring the progress achieved, highlighting areas in need, creating ambitious goals and pragmatic targets, and producing indices for health equity. Social determinants were relevant to communicable and noncommunicable diseases, outbreaks and crises, and were therefore essential to health sector actions. The design of health systems, including financing and the deployment and training of health workers, should be informed by social determinants. Social determinants could also help to align comprehensive primary health-care reforms and accelerate the achievement of health-related goals, such as the Millennium Development Goals.

Health should be an integral part of all public policy; using families as entry points, community-based interventions and universal social protection were critical to overcoming health inequities. In that regard, the collaboration of WHO, its sister multilateral organizations and partners, other bodies and society was essential. Results could be achieved through global, not just national, action; that was the case for issues such as trade, the environment and the current financial crisis. He looked forward to participating in the multiple meetings organized to follow up the recommendations in the report.

He thanked Member States for their efforts in that area over the past four years and praised the work of the Commission and its Chairman, Sir Michael Marmot.

The DIRECTOR-GENERAL expressed her deep appreciation of Dr Lee Jong-wook's vision in creating the Commission on Social Determinants of Health. She commended Sir Michael Marmot and the commissioners for their work, and thanked Member States and the global networks of experts and civil society, for their contribution to the work of the Commission. She looked forward to the guidance, support and collaboration of Member States in implementing the recommendations in the report, which emphasized key values of equity, social justice and global solidarity.

The CHAIRMAN said that the item should be kept open pending the conclusions of the informal working group.

It was so agreed.

(For adoption of the resolution, see summary record of the eighth meeting, section 2.)

Monitoring of the achievement of the health-related Millennium Development Goals: Item 4.7 of the Agenda (Document EB124/10)

Dr KAMOTO (Malawi), speaking on behalf of the Member States of the African Region, said that some progress had been made but much remained to be done; current trends suggested that many low-income countries in the Region would not attain the Millennium Development Goals.

With regard to Goal 5, six countries in the Region had achieved universal coverage of skilled care at birth. However, there were still high levels of mortality in the Region resulting from complications during pregnancy and childbirth: in some countries the maternal mortality ratio was 500 per 100 000 live births. Additional support from WHO and its partners was needed.

The target for Goal 6 on tuberculosis control had been achieved by the Comoros, Ghana, Mauritius, the Seychelles and Sao Tome and Principe; furthermore, Algeria, Angola, Benin, Cape Verde, Eritrea, Guinea-Bissau and Mali were likely to achieve that target. However, the large numbers of people living with HIV/AIDS in sub-Saharan Africa (comprising 67% of the total worldwide), the spread of drug-resistant strains of *Mycobacterium tuberculosis*, and the growing number of refugees and internally displaced people were all factors that contributed to the increased incidence of tuberculosis. The treatment and containment of HIV/AIDS was improving: by the end of 2007, 42% of those in need were receiving antiretroviral therapy, compared to 17% at the end of 2005.

Malaria morbidity and mortality had been reduced substantially in some countries owing to increased use of insecticide-treated bednets and indoor residual spraying.

With respect to Goal 4, reducing child mortality, some progress had been made in the Region: the number of deaths per 1000 live births had fallen from 187 to 162 between 1990 and 2005.

The Region's slow progress in achieving the health-related Millennium Development Goals was mainly due to its weak health systems, financial problems and a shortage of trained health workers. WHO's renewed commitment to primary health care would enable countries in the Region to build stronger health systems. She appreciated WHO's leadership in promoting implementation of the Paris Declaration on Aid Effectiveness (2005). She welcomed the Director-General's involvement in a high-level task force on innovative international financing, and WHO's work with its partners, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the GAVI Alliance, which were helping to strengthen and finance health systems.

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union and the aligned countries, said that the European Union was committed to annual monitoring of the achievement of the health-related Millennium Development Goals. Results thus far had shown uneven progress among countries and some Goals would not be met, particularly those relating to mothers and children under five. The European Commission, the European Union and its Member States had oriented development cooperation policies towards the objective of eliminating poverty and currently provided 57% of all official development assistance. Member States that had joined the Union before 2002 had committed to reaching the target for such assistance of 0.7% of gross national income by 2015.

The Annual Ministerial Review of the United Nations Economic and Social Council would highlight the health-related Millennium Development Goals. Challenges to achievement of those goals included: strengthening health systems; expanding access to health services; addressing the shortage of skilled health professionals; and building new infrastructure. He also highlighted financial access to health services through social security mechanisms, such as individual insurance schemes, tax-based

funding systems or individual cash-transfer approaches; attending to health in fragile States; and enhancing harmonization among donors and alignment with national policies and plans.

The European Union was promoting, in addition to gender equality, comprehensive sexual and reproductive health programmes; the provision of high-quality antenatal and postnatal care; skilled care during childbirth and family planning services. It had also intensified combat of poverty-related diseases, in particular HIV/AIDS, tuberculosis and malaria, and emphasized prevention, treatment, care and support. It was taking actions, including funding and support, to deal with the shortage of health workers in developing countries. It also supported WHO's immunization activities and its close collaboration with the GAVI Alliance and the Global Fund to Fight AIDS, Malaria and Tuberculosis.

For several decades, the development assistance community had worked with people and governments of developing countries to improve health and living conditions. Progress, though often unrecognized, had been remarkable. Over the previous 30 years, life expectancy had increased by more than 20 years, infant mortality had dropped by half and primary school enrolment had doubled. Poverty could be overcome; however, the battle was far from over. The Millennium Development Goals could still be achieved in most countries if concerted action was increased immediately and sustained until 2015. WHO's leadership role would facilitate the crucial close cooperation needed between governments and nongovernmental partners.

Dr ABABII (Republic of Moldova) said that his Government had been integrating the achievement of the Millennium Development Goals into its economic, development and health policies, and strengthening the health services to new requirements, particularly for vulnerable populations. Progress had been made. Child mortality had fallen by one third, from 16.3 per 1000 in 2001 to 11.2 per 1000. The maternal mortality ratio was 15.8 per 100 000 live births in 2007, compared to about 45 per 100 000 in 2001. Continued improvement in rates of maternal morbidity and mortality would depend on improved access for mothers to high-quality services and primary health care.

In order to achieve Goal 6 (combat HIV/AIDS, malaria and other diseases), his Government had enhanced legislation, strategic planning, organization and monitoring activities. Antiretroviral medicines were currently being provided to some 700 people in Moldova, including prison inmates, and the number was rising. Tuberculosis remained a major problem: morbidity had been rising steadily since 2000, and although the situation had stabilized there were still more than 100 cases per 100 000 population. A national control and treatment programme based on the DOTS strategy had been established, but the country had remained unable to meet the WHO target of detecting at least 70% of cases. Moreover, only 60.8% of patients were treated successfully, well under the WHO target of 85%. Measures had been taken to strengthen screening, prevention and social support, but results had been modest. The emergence of extensively drug-resistant tuberculosis had further increased the risk of transmission of the disease. The situation was exacerbated by high levels of population migration. A mechanism for regional cooperation in treating and monitoring tuberculosis patients was badly needed. New methods for the diagnosis, treatment and prevention of tuberculosis were also needed. Therapies had not changed for many years. WHO should make research into tuberculosis a priority; such research should not be postponed for financial reasons.

Dr REN Minghui (China) said that achievement of the health-related Millennium Development Goals would be made more difficult by the financial crisis and climate change. As the world's most populous country, China's achievement of those goals would have an important global impact.

In China, the target under Goal 4 had been achieved, partly as a result of improved accessibility to public health services: infant mortality had fallen from 50.2 per 1000 live births in 1991 to 15.3 in 2007. Maternal mortality had fallen from 53 per 100 000 live births in 2000 to 36.6 in 2007.

The nationwide elimination of filariasis had been achieved in 2006 and vaccination coverage for children had been extended, with effective control of vaccine-preventable diseases. The spread of HIV had slowed and the prevalence of malaria and tuberculosis stabilized. His Government had recently approved health reforms with a view to achieving the goal of Health for All. China stood

ready to strengthen international cooperation in order to help achieve the Millennium Development Goals, especially in Africa.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland), emphasizing his Government's commitment to the achievement of the Millennium Development Goals, expressed satisfaction at the progress made in reducing child mortality, and acknowledged the need to consolidate and accelerate support for effective strategies. His Government remained concerned that there had been no measurable progress in reducing maternal mortality since 1990. In that regard WHO must prioritize the strengthening of health systems in 2009. Highlighting organizational reform and cooperation with international agencies and global initiatives, he urged WHO to use the International Health Partnership in order to harmonize the health support of national plans. Any draft resolution on the issue should aim to analyse further countries' performance and ascertain the factors that led to success, and those that created barriers to progress towards the Goals.

It was important to secure past gains and to advance towards the Millennium Development Goals. His Government would provide, in addition to its previous commitments to meeting the health-related Goals and its contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria, a further £100 million over the next five years to maintain the campaign to eradicate poliomyelitis. Achieving that objective would make a valuable contribution to the attainment of Goals 1, 4, 6 and 8.

Ms GARBOUJ (alternate to Dr Abdesselem, Tunisia), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that achievement of the Millennium Development Goals by 2015 would be difficult in many parts of the world. Maternal and under-five child mortality remained high in one third of the countries of her Region. Those countries were in the grip of a protracted humanitarian crisis and the underlying cause was poverty.

She called upon WHO and the international community to strengthen the capacities of communities in the Region to break free from poverty; to break down social and economic barriers; to promote equity and health equity in particular; to improve the performance of health services; to promote equitable access to those services; to strengthen human resources; and to address social determinants that affected health outcomes. Action to deal with the underlying causes of poor health and social conditions could, through community empowerment, contribute to the achievement of the health-related Millennium Development Goals. Greater investment was needed, especially in the countries that had made the least progress. States should engage in South-South cooperation, share experiences and strengthen their reporting and monitoring systems.

The meeting rose at 12:35.