



WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD

128TH SESSION

GENEVA, 17–24 JANUARY 2011

SUMMARY RECORDS

GENEVA
2011

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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

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

PREFACE

The 128th session of the Executive Board was held at WHO headquarters, Geneva, from 17 to 24 January 2011. The proceedings are issued in two volumes. The present volume contains the summary records of the Board's discussions, the list of participants and officers, and details regarding membership of committees and working groups. The resolutions and decisions and relevant annexes are published in document EB128/2011/REC/1.

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- M. Implementation by WHO of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors (resolution WHA59.12)

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EB128/1 Rev.1	Agenda
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EB128/2	Report by the Director-General to the Executive Board at its 128th session
EB128/3	Report of the Programme, Budget and Administration Committee of the Executive Board
EB128/4	Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits
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EB128/33	Reports on meetings of expert committees and study groups
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Information documents

EB128/INF.DOC./1	Statement by the representative of the WHO staff association
EB128/INF.DOC./2	The future of financing for WHO: summary of a consultation
EB128/INF.DOC./3	The future of financing for WHO

Diverse documents

EB128/DIV/1 Rev.1	List of members and other participants
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Thirteenth meeting, 13 and 14 January 2011: Dr A.J. Mohamed (Oman, Chairman), Professor A.F.M.R. Haque (Bangladesh), Mrs B.B. De Souza E Silva (alternate to Dr P. Buss, Brazil), Dr N. Birintanya (Burundi), Ms J. Billings (alternate to Dr K. Dodds, Canada), Dr Ren Minghui (China), Mr S. Chatelus (alternate to Mr D. Houssin, France), Mr B. Kümmel (alternate to Dr E. Seeba, Germany), Dr M. Kökény (Hungary, member ex officio), Mr S. Prasad (alternate to Mr K. Chandramouli, India), Dr M. Mugitani (alternate to Dr S. Omi, Japan), Mr J. Hazim (alternate to Mrs Y. Baddou, Morocco), Ms M. Hanjam Soares (Timor-Leste).

2. Standing Committee on Nongovernmental Organizations

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Meeting of 18 January 2011: Professor A. Babloyan (Armenia), Professor A.F.M.R. Haque, (Bangladesh, Chairman), Dr A.J. Mohamed (Oman), Mrs G.A. Gidlow (Samoa), Dr J. Gedeon (Alternate to Dr B. Valentin (Seychelles)).

3. Ihsan Doğramacı Family Health Foundation Selection Panel

The Chairman of the Executive Board, a representative of the International Children's Center, Ankara, and the President of Bilkent University or his or her appointee.

Meeting of 18 January 2011: Dr M. Kökény (Hungary, Chairman), Professor P.L. Erdogan, appointee of Professor A. Doğramacı (the President of Bilkent University) and Professor M. Bertan, representing the International Children's Center (Ankara).

4. Sasakawa Health Prize Selection Panel

The Chairman of the Executive Board, a representative of the founder, and a member of the Executive Board.

Meeting of 19 January 2011: Dr M. Kökény (Hungary, Chairman), Mr S. Lambaa, member of the Executive Board for Mongolia, and Professor K. Kiikuni, representing the Founder of the Prize.

¹ Showing current membership and listing the names of those committee members who attended meetings held since the previous session of the Executive Board.

5. United Arab Emirates Health Foundation Selection Panel

The Chairman of the Executive Board, a representative of the founder, and a member of the Executive Board from a Member State of the WHO Eastern Mediterranean Region.

Meeting of 18 January 2011: Dr M. Kökény (Hungary, Chairman), Dr R. Said member of the Executive Board for the Syrian Arab Republic, and His Excellency Mr Obaid Salem Saeed Al Zaabi, representing the Founder of the Prize.

6. State of Kuwait Health Promotion Foundation Selection Panel

Chairman of the Executive Board, a representative of the founder, and a member of the Executive Board from a Member State of the WHO Eastern Mediterranean Region.

Meeting of 18 January 2011: Dr M. Kökény (Hungary, Chairman), Dr A.J. Mohamed, Member of the Executive Board for Oman, and Mr N. Naman, representing the Founder of the Prize.

7. Dr LEE Jong-wook Memorial Prize Selection Panel

The Chairman of the Executive Board, a representative of the founder, and a member of the Executive Board from a Member State of the WHO Western Pacific Region.

Meeting of 19 January 2011: Dr M. Kökény (Hungary, Chairman), Ms P.T. Toelupe (alternate to Mrs G.A. Gidlow, member of the Executive Board for Samoa), and Professor Sohn Myongsei, Representative of the Founder.

SUMMARY RECORDS

FIRST MEETING

Monday, 17 January 2011, at 09:35

Chairman: Dr M. KÖKÉNY (Hungary)

1. OPENING OF THE SESSION AND ADOPTION OF THE AGENDA: Item 1 of the Provisional Agenda (Documents EB128/1 and EB128/1(annotated))

The CHAIRMAN declared open the 128th session of the Executive Board and welcomed all participants, in particular three new members of the Board: Mr Yusof (Brunei Darussalam), Mr Chandramouli (India) and Dr Lukwago (Uganda). He noted that Mr Yusof had replaced Dr Osman as the Board member designated by Brunei Darussalam.

The CHAIRMAN drew attention to the recommendations that had been made by the officers of the Board on the draft provisional agenda (as detailed in the note at the end of document EB128/1 (annotated)).

Dr BIRINTANYA (Burundi), speaking on behalf of the Member States of the African Region, proposed that provisional agenda item 8.1, Election of the Director-General of the World Health Organization, should be taken up at the earliest opportunity in order to ensure ample time for discussion of that sensitive issue.

Dr BUSS (Brazil), Mr GOPEE (Mauritius), Mr HAZIM (adviser to Mr El Makkoui, Morocco), Dr KHABBAZ HAMOUI (alternate to Dr Said, Syrian Arab Republic) and Dr RASAE (Yemen) expressed support for the proposal by the member for Burundi.

The CHAIRMAN noted that the proposed draft resolutions on provisional agenda item 8.1, Election of the Director-General of the World Health Organization, would not be made available to the Board until later and suggested that members should therefore take up consideration of the item during a subsequent meeting.

It was so agreed.

(For consideration of the item, see the summary record of the third meeting, section 2.)

Dr PÁVA (alternate to Dr Kökény, Hungary), speaking on behalf of the Member States of the European Union, said that, as agreed in the exchange of letters in 2000 between WHO and the European Commission on the consolidation and intensification of cooperation, and without prejudice to any future general agreement between WHO and the European Union, the European Union attended sessions of the Board as an observer. However, under Rule 4 of the Board's Rules of Procedure, observers were not automatically invited to participate in the work of subcommittees or other subdivisions of the Board, such as drafting groups and working groups. She requested that, at the current session, as at previous sessions, the European Union should be invited to participate without vote in the meetings of the Board and its committees, subcommittees or other subdivisions that

addressed matters falling within the European Union's competence, in particular provisional agenda items 4 and 10.

The CHAIRMAN took it that the Board wished to agree to the request.

It was so agreed.

Dr JADUE (Chile) recalled that she had circulated to Board members a draft resolution on emergency and disaster management and proposed that it should be considered under provisional agenda item 4.5, Health system strengthening. The draft resolution was aimed at enhancing WHO's capacity to lead an effective coordinated response to health emergencies and disasters, and she hoped that it would receive wide support from Board members.

Dr BUSS (Brazil) expressed support for the proposal and the draft resolution put forward by the member for Chile.

Professor HAQUE (Bangladesh), noting the seriousness and urgency of the problem of cholera, suggested that provisional agenda item 4.10, Cholera: mechanism for control and prevention, should be discussed at the earliest opportunity.

The CHAIRMAN conveyed a suggestion by the Secretariat that provisional agenda item 4.10 should be discussed immediately following provisional agenda item 4.4, Health-related Millennium Development Goals.

It was so agreed.

The CHAIRMAN took it that the Board wished to adopt the agenda, taking into consideration the comments made by members.

It was so decided.

The agenda was adopted.¹

2. REPORT BY THE DIRECTOR-GENERAL: Item 2 of the Agenda (Document EB128/2)

The DIRECTOR-GENERAL, presenting her report, noted that 2010 had seen several public health triumphs, including the launch of a new meningitis vaccine that had the potential to end epidemics of meningococcal meningitis in Africa. The development of the vaccine showed how public health needs could drive product innovation through partnerships. It remained to be seen, however, whether recent public health gains could be maintained and current and future obstacles surmounted in the face of resource shortages and the continuing effects of the financial crisis. Health system strengthening, one of the items on the Board's agenda, was essential in order to enhance response capacity, increase countries' self-reliance and achieve global health goals, including the health-related Millennium Development Goals.

Although WHO was strikingly effective in some areas in her report, it was increasingly apparent that the Organization was overextended. Administrative, budgetary and programmatic changes were needed in order to ensure that WHO could perform at top capacity. In their discussion of the future of

¹ See page ix.

financing for WHO, Board members would need to give careful consideration to WHO's purpose and unique contribution, bearing in mind that the level of its involvement in a particular health problem should be determined not by the size of the problem but by the impact that the Organization could have on it. She looked forward to hearing members' views on what the roles and responsibilities of WHO should be and how far they should extend.

Dr GOPEE (Mauritius), speaking on behalf of the Member States of the African Region, welcomed the Director-General's candid assessment of the current global health-related challenges and of the future functioning of WHO. He expressed gratitude for her efforts to respond to the Region's specific health needs through innovative approaches and partnerships such as the one that had led to the meningitis vaccine project.

The challenges highlighted by the Director-General required a collective response. That was particularly true of the future of financing for WHO, on which the Member States in the Region had held lengthy discussions. Many countries in the Region considered that WHO should continue to take the lead in global health governance and global consultations on health issues, that its priorities and action plans should be driven by Member States rather than donors, that its partners' policies and responsibilities needed to be streamlined and aligned so that WHO remained at the centre of international health issues, and that sustainable, flexible and predictable funding sources must be found to support its work. Member States must seek reforms that would increase the efficiency and effectiveness of WHO and enable it to fulfil its core functions. They must also reach consensus on the complex question of geographical rotation of the post of Director-General. The Member States of the Region did not consider that merit and competence were the monopoly of any specific region.

Professor SKVORTSOVA (alternate to Professor Starodubov, Russian Federation), noting that the increasing number of tasks entrusted to the Organization required greater resources, expressed support for the Director-General's reform initiative. Her country would cooperate closely with the Secretariat in that process. One of the Organization's foremost achievements had been the establishment of an up-to-date knowledge base, which enabled the collection, collation and analysis of information on health technology and facilitated the preparation of strategies and the development of legislation. Effective use of new technologies was needed through the exchange of information and adaptation of that information to target audiences. With a relatively low financial outlay, it would be possible to ensure that relevant information reached national authorities, medical professionals and patients.

Her country had acquired considerable experience in health system strengthening and would gladly share its expertise with the Secretariat and fellow Member States, especially in the European Region. The Russian Federation had recently taken many steps to develop and implement an intersectoral preventive health-care programme, to improve infrastructure, to raise awareness about the importance of prevention and healthy lifestyles through education and information campaigns, and to enact health-related laws. Results were already being seen, including a three-year increase in life expectancy and a decrease in mortality from several noncommunicable diseases. She invited all Member States to attend the First Global Ministerial Conference on Noncommunicable Diseases and Healthy Lifestyles, to be held in Moscow in April 2011.

Professor HAQUE (Bangladesh) expressed appreciation for the Director-General's overview and welcomed the progress that had been made since the Sixty-third World Health Assembly in the areas of financing for research and development and pandemic influenza preparedness. He looked forward to further progress through inclusive and transparent consultations.

The United Nations High-level Plenary Meeting on the Millennium Development Goals (New York, 20–22 September 2010) had drawn attention to the continuing need to scale up efforts globally in order to achieve the Goals; the international community had the means to do so both efficiently and effectively but would need to remain engaged and to give due attention to the needs of the most vulnerable and poor. He welcomed the Director-General's emphasis on preventing and combating noncommunicable diseases, which were a major global health challenge, and looked

forward to the recommendations that would emerge from forthcoming discussions on the subject in 2011.

The global health community needed to prioritize the issue of climate change and its impact on health. The many recent natural disasters were evidence of the growing challenges in that area. Without increased efforts and appropriate mitigation measures, the situation would only worsen and place greater strain on health system capabilities.

Recalling that the Board at its 127th session had decided to defer further consideration of a draft resolution on cholera that Bangladesh had submitted,¹ he expressed the hope that the Board would adopt the revised version of that draft resolution when it considered agenda item 4.10.

Dr PÁVA (alternate to Dr Kökény, Hungary), speaking on behalf of the European Union, welcomed the opportunity to discuss issues that would determine the future of WHO in the long term. The Board's discussions on its role, the future of financing for the Organization and the election of the Director-General would be especially important. The discussion of the latter item should be constructive and solution-oriented.

An increasing number of health-related activities were being carried out by other organizations within the United Nations system and across a range of sectors. She welcomed activities such as the recent United Nations High-level Plenary Meeting on the Millennium Development Goals and the forthcoming meetings on HIV/AIDS and noncommunicable diseases, but stressed that leadership in global health matters should remain with WHO. She also welcomed the choice of antimicrobial resistance as the topic of World Health Day 2011; that would help to focus global attention on a worrying phenomenon.

Mrs GIDLOW (Samoa) expressed sympathy with the many countries that had suffered serious natural disasters and the adverse effects of climate change in recent times. She commended the Secretariat's support of those countries, including Samoa. She welcomed the Organization's continued focus on women's and children's health and the growing recognition of noncommunicable diseases as a threat to health globally.

Professor MILOSAVLJEVIĆ (Serbia) said that, in the face of crises related to the global economy, climate change and disease pandemics, WHO had an important role to play in raising awareness of the importance of public health and in keeping investment in health high on the political agenda, as such investment was vital to stable and sustainable development at the national, regional and global levels. *The world health report 2010*² had made a valuable contribution in that regard.

Dr REN Minghui (China), recalling the natural disasters experienced in 2010 in Haiti, Pakistan and elsewhere, said that, although there had been swift mobilization of emergency relief, the arduous process of reconstruction and of grappling with the many health-related challenges was continuing. The international community and WHO should strengthen their support for such activities, which were vital for the attainment of the health-related Millennium Development Goals. The United Nations High-level Plenary Meeting of the General Assembly in September 2010 to review progress on the Goals had injected new vitality into the process, but little time remained before their 2015 target date, and steps should be taken to plan the way forward for health-care development after 2015. Member States had high expectations of the leadership and coordinating role of WHO as the United Nations body with responsibility for global health. WHO should also take advantage of the opportunity provided by the high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases, to be held in September 2011; WHO should coordinate with

¹ Document EB127/2010/REC/1, summary record of the first meeting, section 5.

² *The world health report 2010 – Health systems financing: the path to universal coverage*. Geneva, World Health Organization, 2010.

other organizations in the United Nations system during the preparations for the meeting and draw the attention of world leaders to the issue.

The Board would be considering the Proposed programme budget 2012–2013 and the financial difficulties being faced by the Organization. Internal reforms were needed to improve cost effectiveness, but alone they would not be sufficient; Member States must consider their own responsibilities and obligations. China would continue to support the work of WHO.

Dr MOHAMED (Oman) said that the Director-General's report underlined WHO's main focus on the prevention and control of diseases. It was essential to respond rapidly to disease outbreaks and to the emergence of new diseases, and to provide targeted technical support to countries that matched their needs. WHO had an important role to play in coordinating the transfer of disease prevention and control technologies to countries that needed them. WHO had shown that it could achieve success when it acted promptly and appropriately. Nevertheless, since some countries had shown little progress in certain areas, it was worth considering whether Member States were participating fully enough and providing adequate sustained support for the establishment and implementation of WHO programmes. In considering the future of WHO, the Board would need to look beyond the next biennium and envisage longer-term approaches to financing and to programming that would respond to changes in disease patterns.

Dr OMI (Japan) congratulated the Director-General and her staff on the many achievements over the previous year, despite considerable financial difficulties. The launch of the new meningitis vaccine was especially noteworthy.

He welcomed the decreasing trend in three of the four countries where poliomyelitis remained endemic, but noted that serious obstacles to eradication remained. The oral poliovirus vaccine was still not reaching children in some areas in some countries, especially in cases of insecurity and conflict, as in Pakistan. The last stage of eradication was always the most difficult and required a concerted effort. Health ministers were fully committed but Heads of State and Government must also show that political will. He suggested that the United Nations General Assembly should be requested to hold a meeting on poliomyelitis eradication as soon as possible, preferably in 2012. He also urged the Secretariat to make appropriate preparations for the United Nations high-level meeting in September 2011 on the prevention and control of noncommunicable diseases.

Japan had developed new tools for the diagnosis of tuberculosis and was ready to make them available to others, especially the developing countries, through WHO.

Dr RASAE (Yemen) said that the effectiveness of WHO's efforts in respect of pandemic (H1N1) 2009 had been recognized, but in some cases there had been an overreaction to the outbreak, possibly motivated by fear to the extent that, in the wake of the pandemic, relations between health officials and the media must be re-examined in order to establish mutual trust. He welcomed the progress made in African and Arab Member States in combating vaccine-preventable diseases with the support of the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria, but priorities had to be adjusted and new partners sought, including those in the private sector and wealthier countries, in order to secure the additional extrabudgetary funding required to ensure adequate supplies of vaccines. Bodies such as the Global Fund continued to raise funds successfully. He commended WHO's efforts to reduce maternal mortality. Yemen was seeking support for the further development of its network of maternal and child health centres in order to improve maternal health further and to expand activities to reduce vaccine-preventable diseases and therefore child mortality, which remained worryingly high. With regard to the reforms to be undertaken in order to enable the Organization better to meet the expectations of Member States, he encouraged the Director-General to seek ways of reducing bureaucracy.

Mrs HANJAM DA COSTA SOARES (Timor-Leste), speaking on behalf of the Member States of the South-East Asia Region, said that the Director-General's report had drawn attention to the numerous challenges facing developed and developing countries alike, including noncommunicable

diseases, natural disasters and climate change. There was clearly a need for further support from WHO to increase access to health services. Member States should work together to develop and implement common policies for improving health around the world.

Professor HOUSSIN (France) observed that, although 2010 had seen the end of pandemic (H1N1) 2009, it was essential to remain vigilant as there remained a risk of epidemics of diseases such as cholera, poliomyelitis and avian influenza in several countries. The year had also seen several natural disasters and WHO must therefore continue to strengthen emergency preparedness and response capacity. The International Health Regulations (2005) provided a solid instrument for that purpose, and it was incumbent on Member States to ensure their effective and efficient implementation. He looked forward to the results of the work of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to pandemic (H1N1) 2009. He applauded WHO's efforts during the pandemic, but there was clearly room for improvement in several areas, including access to vaccines, organization of immunization campaigns, coordination of communications, and credibility of the independence of expertise. The establishment of national and regional alert networks was essential in order to provide a clear strategic operational framework. It would also be useful to develop technical guidelines for an "all-hazards" approach to risk assessment and management.

He commended the Organization's work on the meningitis vaccine initiative, neglected tropical diseases, the environment and health, and the issue of health system financing, which was crucial to the achievement of universal coverage. The recent United Nations high-level meeting on the Millennium Development Goals had demonstrated the crucial role of WHO in relation to maternal and child health, and he therefore welcomed the establishment, under WHO's leadership, of the high-level commission to track results in that area and looked forward to its imminent first meeting. Although the Health Assembly had adopted in May 2010 the Global Code of Practice on the International Recruitment of Health Personnel (resolution WHA63.16), further efforts were needed to implement the Code and monitor its observance.

The Board's heavy agenda revealed the broad range of health matters currently being addressed by WHO. In the current economic climate, the question of the future of financing for WHO was pertinent. Strategic choices would have to be made and a better method found for linking those choices with budget estimates and operational decisions.

Dr DAULAIRE (United States of America) said that the Director-General's report had clearly differentiated WHO, as a specialized technical agency, from the political bodies of the United Nations system. He identified seven fundamental principles in the report that should guide the Board's debate on the various agenda items: the Organization should prepare for the worst; plan practically for the probable; prioritize action and funding for the necessary, especially for activities benefiting the poor and powerless; stimulate and support meaningful innovation; measure and disseminate results for the purposes of accountability and improvement; find efficiencies to reduce costs and simplify processes; and follow science, leaving polemics to others.

Mr YUSOF (Brunei Darussalam) agreed that, given the broad scope of the public health challenges facing the Organization, it should set priorities, develop coherent strategies and seek innovative approaches. He was confident that, under the Director-General's leadership, WHO would be even more successful in improving global health in 2011. The Board's agenda would provide the opportunity to share information and experiences.

Mr CHANDRAMOULI (India) welcomed the Director-General's continued commitment to enhancing equity and increasing the availability of affordable medicines through the development and use of generic drugs. WHO should continue to provide technical leadership on public health challenges, one of which was rising financial requirements. India was committed to continuing its support for the Organization.

Mr LARSEN (Norway) said that WHO should remain the global leader on health matters. It was especially important for WHO to deal effectively with events such as pandemic (H1N1) 2009. He therefore welcomed the review of the functioning of the International Health Regulations (2005) in relation to the pandemic and expressed regret that the Review Committee's report was not available for consideration by the Board at the current session. Noncommunicable diseases accounted for a growing proportion of global mortality. It was to be hoped that two important events to be held during 2011 would yield significant progress in tackling that serious problem: the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Diseases, to be held in Moscow in April, and the high-level meeting of the United Nations General Assembly on noncommunicable diseases, to be held in September.

Dr ALHAJ HUSSEIN (alternate to Dr Said, Syrian Arab Republic) pledged his country's support for the high-level meeting on noncommunicable disease, which ought to result in practical solutions. Every effort was being made to ensure the success of the WHO Global Policy Group meeting to be held in his country in March 2011, which would be attended by the Director-General and the six Regional Directors.

Dr LUKWAGO (Uganda) said that the Director-General's report had highlighted the need to involve the international community in responding to health challenges in both developed and developing countries. He welcomed the focus on preparedness for health emergencies arising as a result of disasters, which were a serious concern in the African Region, particularly emergencies caused by the misuse of weapons of war.

Dr JADUE (Chile) said that the increasing burden of noncommunicable diseases was a problem of enormous magnitude. Vigorous action was needed to curb the pandemics of obesity, diabetes and hypertension. The high-level meeting of the United Nations General Assembly in September 2011 was therefore most timely and would provide an excellent opportunity to coordinate a multisectoral response.

Dr BUSS (Brazil) welcomed the Director-General's reference to the importance of the social and economic determinants of health and noted that the World Conference on the Social Determinants of Health, due to be held in Rio de Janeiro (Brazil) in October 2011, would afford an additional opportunity to discuss the matter. Brazil had recently elected its first woman President. Health had been a major issue during the electoral campaign, and, upon taking office on 1 January 2011, the President had immediately emphasized her Government's commitment to continue previous policies to expand public services, including health services. The new Minister of Health had affirmed his commitment to Brazil's unified health system and to an intersectoral approach to the determinants of health. Brazil would continue its collaboration with WHO and PAHO, and was committed to strengthening international cooperation on health.

Dr NARVÁEZ (Ecuador) agreed with previous speakers on the need for WHO to take a more aggressive approach to noncommunicable diseases. Strategies should be sought to facilitate access to the medicines used to treat such diseases, especially among vulnerable populations. Such strategies should include policies to permit expanded use of generic medicines.

Dr ST JOHN (Barbados), expressing sympathy for the continuing suffering of the Haitian people, welcomed the Director-General's recognition of the importance of disaster preparedness and health system strengthening. The financing and strengthening of health systems had long been on the cooperation agenda of the Caribbean Community, whose member countries had experienced a chronic lack of financial and human resources for health. The subregion was subject to hurricanes annually but had learnt to regroup rapidly, especially as national economies depended heavily on tourism. It relied on preventive medicine and primary health-care facilities to keep its populations healthy, focusing on areas where it was possible to achieve the greatest impact. Initiatives related to the International

Health Regulations (2005) had assisted countries in anticipating health challenges. The governments of the Caribbean Community countries had committed themselves to combating noncommunicable diseases and looked forward to the United Nations high-level meeting in September 2011 on the subject. The Caribbean Community countries were striving to protect health gains despite the economic situation and looked to future WHO financing policies and reforms that should provide guidance for weathering the difficult times.

Dr CÓRDOVA VILLALOBOS (Mexico)¹ noted that Mexico was co-chairing, with Norway, the Open-Ended Working Group of Member States on Pandemic Influenza Preparedness: sharing of influenza viruses and access to vaccines and other benefits. It was essential to reach agreement on a framework for the sharing of influenza viruses and other benefits by April 2011. The aim was to achieve an efficient, transparent and equitable system for pandemic preparedness and response that encompassed the strengthening of laboratory and surveillance capacity, an increase in worldwide influenza vaccine production, and improvements in distribution and access to vaccines, antiretroviral medicines and diagnostic materials.

He thanked WHO for its support for the meeting on climate change and health held during the Sixteenth session of the Conference of the Parties to the United Nations Framework Convention on Climate Change (Cancún, Mexico, 29 November – 10 December 2010). Information on the impact of climate change on health was needed in order that preventive action could be taken, and he urged Member States to develop sound strategies and implement appropriate activities in that area.

His Government prioritized prevention and control of noncommunicable diseases, and would host a regional ministerial conference on the issue in February 2011. It also gave high priority to road safety, with a multisectoral initiative to reduce road traffic fatalities, and would host an Ibero-American meeting on that topic in May 2011. It was also working with FAO, WHO and OIE to define the objectives for an intersectoral ministerial meeting to address health risks at the human–animal ecosystem interface, to be held in November 2011 in Cancún. In addition, it was seeking to introduce a public health insurance system that would provide universal health care coverage by 2011.

Mr MANZOU (Zimbabwe)¹ welcomed the Director-General's emphasis on the health status of African people, especially women and children, and acknowledged WHO's efforts to combat the many diseases endemic to the African Region. Reform of the Organization at the budgetary, administrative and programmatic levels would improve its performance and effectiveness, but would not be sufficient to overcome the many public health challenges. There also had to be matching changes in the way Member States contributed to and supported the Organization. Donor contributions, although greatly appreciated, should be provided in a manner that supported the achievement of mutually agreed objectives and priorities. The conditions attached to earmarked voluntary funding, which was sometimes supported through assessed contributions, hindered effective planning and prioritization in the context of agreed strategic directions, and adversely affected staff morale. Sustainable, predictable and flexible financing of the WHO budget was essential. WHO should continue to seek new donors and sources of financing that would facilitate realistic planning and improve clarity of purpose, efficiency and transparency. It should also exercise leadership in coordinating the efforts of an increasingly complex array of partnerships and other international participants in the global health arena in order to avoid duplication of effort and vertical programmes with a narrow focus. Zimbabwe pledged its commitment to the search for meaningful and sustainable solutions for the financing of WHO.

Dr MUKUKA (Zambia)¹ welcomed the progress made in WHO's various programme areas during 2010 and acknowledged the technical support provided to her country for the development of a training package for health workers on integrated infant and young child feeding. She looked forward

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

to the benefits that would accrue from the launch of the new meningitis vaccine, to the development of which, it was heartening to note, African scientists had contributed. Their further involvement in research and development and in promotion of the local production of pharmaceuticals and other medical products was to be encouraged. She therefore commended the establishment of the African Network for Drugs and Diagnostics Innovation. WHO should continue efforts to mobilize financial resources and to set priorities with a focus on activities that were likely to have a high impact on people's lives. Consideration of the future financing for WHO must address the current imbalance between assessed contributions and voluntary funding in order to ensure predictable and sustainable funding, and permit better planning and priority-setting. Partners should be encouraged to provide support in accordance with agreed priorities. Adequate financing for crucial programmes must be ensured in order to preserve and accelerate public health gains.

Dr PARK Ha-Jeong (Republic of Korea)¹ commended the Director-General's leadership of the global response to pandemic (H1N1) 2009 and work towards the health-related Millennium Development Goals. Efforts to achieve the Goals should be stepped up, with translation of international commitments into real progress through careful analysis of the current situation and allocation of appropriate budgets based on priorities. His Government had pledged additional funding to support maternal and child health programmes in developing countries and remained committed to attainment of the Goals. Many Member States were experiencing rapid increases in noncommunicable diseases as a result of lifestyle changes, and WHO and the international community should pay greater attention to their prevention and control. His Government was implementing various policies in that area, including anti-smoking campaigns, and was organizing, jointly with the Regional Office for the Western Pacific, a regional meeting on noncommunicable diseases, to be held in March 2011. It was also seeking to sustain health-care financing in the face of a rapidly ageing population. Antibiotic resistance was a growing problem, posing a serious threat to human health, he therefore welcomed the choice of that issue as the theme for World Health Day 2011. Sentinel surveillance of six types of multidrug-resistant bacteria was being introduced and his country would collaborate actively with other Member States to ensure sharing of information on surveillance and policy performance. Member States must continue working together to overcome global health challenges.

Dr OKEYO-MBOYA (Kenya)¹ endorsed the views of previous speakers concerning the role of WHO: the Organization should focus on coordinating health activities within the United Nations system and not duplicate work being carried out competently by other bodies in the area of global health and development. His country remained committed to WHO's work in accordance with its mandate as set out in the Organization's Constitution and in the Charter of the United Nations. Member States must remain engaged and support the Organization in reforms; WHO must remain relevant in a changing world. The future of financing for WHO was clearly a major challenge, with five priorities for action: improving the efficiency and effectiveness of implementation of the International Health Regulations (2005), especially in the 33 Member States identified as having the most vulnerable health systems; improving implementation of the global strategy on public health innovation and intellectual property in order to increase access to medicines, particularly for the treatment of neglected and noncommunicable diseases; strengthening the role of WHO's country representatives in supporting the mobilization of domestic funding for health and reducing dependence on external resources; promoting harmonization to reduce waste in the use of international health funding; and commissioning a comprehensive external independent review of the Secretariat with a view to increasing efficiency and effectiveness through, for example, improvements in the global management system and strategies to reduce earmarking of voluntary funding. In addition, greater support in the form of non-earmarked contributions should be sought from middle-income countries such as Brazil, China and the Republic of Korea.

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

Mr VICENTI (Italy)¹ commented that, as the world had changed considerably since the establishment of WHO, the Organization must adapt to new circumstances. He supported the focus on reform, future financing and the setting of global priorities, for example in relation to the prevention and control of noncommunicable diseases and the implementation of the International Health Regulations (2005), which required increased international collaboration and strengthening of national capacities. He looked forward to the final report of the review committee on the functioning of the international response to pandemic (H1N1) 2009. He expressed satisfaction at the choice of antimicrobial resistance as the theme for World Health Day 2011 and at the release of the first WHO report on neglected tropical diseases.² He affirmed Italy's support for an increased leadership role for WHO at the global and regional levels, in accordance with its mandate.

Dr LUKWAGO (Uganda) endorsed the comments made by the representative of Kenya.

Dr GOPEE (Mauritius) endorsed the comments made by the representatives of Zambia and Zimbabwe.

Mr NABEEL (Pakistan),¹ welcoming WHO's achievements in 2010, including the launch of the meningitis vaccine, expressed appreciation for the support his country had received during the relief phase following the previous year's floods. Continued support would be required to ensure successful rehabilitation and reconstruction of the health system infrastructure, which had been severely damaged. He underlined Pakistan's commitment to the eradication of poliomyelitis; a plan of action was being implemented across the country and national health authorities would cooperate closely with WHO and donors.

Mrs MALLIKARATCHY (Sri Lanka)¹ said that the end of a long armed conflict had paved the way for an ambitious development agenda for Sri Lanka. Its elevation to middle-income status was reshaping its economy and its connectivity with the rest of the world, and rapid acceleration of economic development was envisaged in the coming years. She expressed appreciation for the support provided by WHO and the international community following Sri Lanka's recent floods. The country, however, faced continuing challenges in ensuring delivery of health-care services in the wake of natural disasters and as a result of the rise in noncommunicable diseases and an ageing population. WHO's role in the new era of global health governance would be crucial for many developing countries.

Mr LUMBANGA (United Republic of Tanzania)¹ commended the work of WHO and the leadership shown by the Director-General, and expressed appreciation for the support provided by the Secretariat to developing countries. He welcomed the Director-General's recognition of the need to foster partnerships in order to ensure expansion of various health programmes, such as those on HIV/AIDS, tuberculosis and malaria. The partnership with the Program for Appropriate Technology in Health for the development of the new meningitis vaccine was especially commendable. The Organization's work needs to be harmonized in accordance with its mandate. However, in pursuing reforms, WHO should not relinquish its core role as a specialized agency providing technical support in health matters. Moreover, the reform process should include active consultation with, and participation of, developing countries from Africa and elsewhere.

The DIRECTOR-GENERAL expressed appreciation for the extensive comments, welcoming the broad support for her analysis of current global health challenges and the calls for WHO to remain

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

² *Working to overcome the global impact of neglected tropical diseases – First WHO report on neglected tropical diseases*. Geneva, World Health Organization, 2010.

true to its mission and core functions. Numerous speakers had reiterated their commitment to working collectively in setting global health priorities and had confirmed that they wished WHO to continue its role as a specialized agency providing technically competent guidance in an effective and efficient manner, reducing bureaucracy wherever possible. The principles and priorities enumerated by the member for the United States of America and the representative of Kenya encapsulated many of the points raised in the Board's rich discussion and would provide useful guidance for her proposals on the future of financing for the Organization. She looked forward to working with Member States in order to strengthen the Organization through a broad range of reforms.

The Board noted the report.

The meeting rose at 13:05.

SECOND MEETING

Monday, 17 January 2011, at 14:50

Chairman: Dr M. KÖKÉNY (Hungary)

1. REPORT OF THE PROGRAMME, BUDGET AND ADMINISTRATION COMMITTEE OF THE EXECUTIVE BOARD: Item 3 of the Agenda (Document EB128/3)

Dr MOHAMED (Oman), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, highlighted the issues in the Committee's report that were not on the agenda of the Board. Those included progress on WHO's management reforms, including the decision by the Region of the Americas/PAHO not to implement the Global Management System; the report of the Independent Expert Advisory Oversight Committee; the report of the Office of Internal Oversight Services; implementation of internal and external audit recommendations; and the reports of the Joint Inspection Unit. He would refer to the Committee's views on items on the Board's agenda when they were taken up.

Ms BILLINGS (Canada) underlined the Committee's important role in promoting accountability and transparency. Its report illustrated the magnitude of the financial and management challenges facing WHO. She expressed particular appreciation for the report of the Independent Expert Advisory Oversight Committee. She stressed the need for a more realistic Proposed programme budget 2012–2013, with the appropriate involvement of the Committee and other Members.

Dr DE ASSUNÇÃO OSWALDO SAÍDE (Mozambique), speaking on behalf of the Member States of the African Region, affirmed that the Regional Office for Africa had introduced the Global Management System in early January 2011. The budget crisis and its effects on the Proposed programme budget 2012–2013 would have implications for the implementation of priority programmes, particularly those relating to the achievement of the Millennium Development Goals and the availability of a specialized workforce for technical support to countries. Priority programmes had to be protected and that needed flexibility in the use of funds. Currently 80% of the Programme budget came from voluntary contributions, most of which were earmarked; that created difficulties for the achievement of agreed priorities. Discussions should continue on sustainable financial mechanisms for effective country support, taking into account lessons learnt from the implementation of previous programme budgets, as part of the exploration of new approaches for overcoming the financial crisis.

Mr LARSEN (Norway) recalled that his country had welcomed the decision to introduce the Global Management System. WHO's substantial investment in that System was yielding visible results. He expressed concern, however, about PAHO's decision not to implement the Global Management System, but instead to modernize its existing system. Although the latter would be fully harmonized with the Global Management System, the differences would impede the effective and transparent running of the Organization and divert limited resources from corporate priorities. He sought a better understanding of the rationale for PAHO's decision, which should have been based on the best interests of WHO as a whole, not those of an individual region.

The report by the Independent Expert Oversight Advisory Committee dealt cogently with issues important to the efficient running of the Organization. The Committee should expand its analysis of such issues in future reports; Norway supported its proposed work programme.

Professor HAQUE (Bangladesh) welcomed the introduction of the Global Management System in the African Region. Noting PAHO's assurance that its management information system would be harmonized with the Global Management System, he requested future updates on that subject. Optimal use should be made of all investments intended to bring about a qualitative change in WHO's management process.

Budgetary funds should be more equitably and logically distributed across the various strategic objectives, in particular those relating to the Millennium Development Goals and noncommunicable diseases, without compromising other critical items on the global health agenda. The projected shortfall in the current biennium was a matter of concern; it should be realistically assessed in order to cope with possible deficits in priority programmes. The ongoing efforts to improve the gender and geographical balance of WHO's staff were welcome, but its competency and mobility should be managed in such a way as to address priority needs, with due regard for skill retention.

The advice of the Independent Expert Oversight Advisory Committee, on reviewing the proposed renewal of the services of the External Auditor, merited consideration by the Executive Board.

Ms OSUNDWA (Kenya)¹ noted the concerns in the report about PAHO's decision not to join the Global Management System. She asked about the implications of that decision for attaining the objectives of the Global Management System and for coherence in the Secretariat's procurement and overall management. The Committee had also asked the Director-General to submit revisions to Staff Rule 420.2 that would tighten the criteria for granting continuing appointments. She supported that objective but opposed the imposition of a moratorium on the granting of such appointments, as suggested in the report, as that appeared arbitrary and punitive.

On the issue of budgeting, she favoured a two-stream process comprising a realistic stream based on assessed contributions plus untied voluntary contributions, and an aspirational stream based on earmarked voluntary contributions, with the latter being managed as contracted services at competitive cost.

The CHAIRMAN said that Staff Rules would be discussed separately under agenda item 9.3.

Dr ROSES PERIAGO (Regional Director for the Americas) said that she understood the concerns expressed about PAHO's decision not to join the Global Management System. The voluminous technical document that had formed the basis for that decision had been circulated to some Member States. The Region of the Americas had been providing data to headquarters long before the advent of the Global Management System and would continue to do so. It had implemented resource-based management and adopted the International Public Sector Accounting Standards before headquarters. She understood that information systems could be adapted to various organizational designs, such as those set up by the Constitutions of both PAHO and WHO. A joint working party existed, and PAHO had benefited from and contributed to the development of the Global Management System. It had created a fund from its arrears for the upgrading and harmonization necessitated by the Global Management System, which should preclude any problems.

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

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

Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: Item 4.1 of the Agenda (Document EB128/4)

Mr HAZIM (adviser to Mr El Makkoui, Morocco), speaking on behalf of the Member States of the Eastern Mediterranean Region, observed that pandemic influenza had very serious consequences for health systems and presented huge challenges to the implementation of the International Health Regulations (2005). Morocco had faced difficulties in providing an adequate response to the recent pandemic.

For the development of new pandemic vaccines there had to be a continued exchange of viruses and samples with WHO collaborating centres, with support, strengthening and improvement of WHO's Global Influenza Surveillance Network; any other approach would endanger international security. The production of one such vaccine, in record time, less than six months, would have been impossible without rapid exchanges of viruses: hence the importance of facilitating such exchanges, as well as the exchange of benefits, within an established framework. Intellectual property rights should be given reduced priority in the face of a pandemic. A mechanism for ensuring financing for pandemic influenza preparedness and response measures should be set up. Given the limited resources for producing vaccines in the Region, a major objective was to ensure affordable access to them. A specific percentage of viruses should be allocated for exchanges, taking into account the needs of countries with few resources and special needs, and continued efforts must be made to strengthen national facilities.

Mr CHANDRAMOULI (India) noted the progress that had been made at the meeting in December 2010 of the Open-Ended Working Group of Member States on Pandemic Influenza Preparedness, but much remained to be done. An international mechanism for pandemic influenza preparedness must be premised on a commitment by Member States to share influenza viruses with pandemic potential and the benefits of work on those viruses on an equal footing. Multiple and complementary approaches and tools must also be used. Two complementary Standard Material Transfer Agreements, within and outside the WHO network, should serve as the legally binding contractual agreements governing virus sharing and benefit sharing. The recently adopted Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization to the Convention on Biological Diversity was entirely consonant with, and supportive of, the principles accepted by Member States for the pandemic influenza preparedness negotiations.

The delay in the preparation of the four technical studies by the Secretariat and their preliminary nature had not only diminished their usefulness but also necessitated another round of negotiations, at considerable cost in time and financial resources. The final documents should be available at least two months before the negotiations on pandemic influenza preparedness due to be held in April 2011. The questions raised on intellectual property issues in the meeting in December 2010 should be addressed by the Secretariat in consultation with WIPO. India welcomed the decision taken by the Working Group's co-chairs to consult civil society, industry and researchers, all integral parts of the solution; a pandemic could be dealt with only through the collective endeavour of all stakeholders.

During the negotiations since 2007 a full-blown H1N1 pandemic had emerged. The advent of the next pandemic could not be predicted. The meeting of the Open-Ended Working Group in April 2011 should be its last, and the outcome submitted to the Sixty-fourth World Health Assembly. Member States must show the necessary political will and flexibility so that a predictable and transparent system with sound legal foundations could be put in place to deal effectively with a future pandemic.

Dr CHISTYAKOVA (adviser to Professor Starodubov, Russian Federation) said that, thanks to the WHO Global Influenza Surveillance Network, appropriate measures had been undertaken at the international and national levels in response to pandemic (H1N1) 2009, thereby minimizing its impact.

Pandemic influenza preparedness in the Russian Federation took the form of laboratory and surveillance capacity building, enhanced production of influenza vaccine, Government-funded immunization of persons in risk groups, and manufacturing of effective antiviral agents and diagnostic kits. Manufacturing live influenza vaccines had been subcontracted and the products had proved both safe and effective in immunizing the population in 2009. Cooperation with the countries of eastern Europe and central Asia played a large part in the Russian Federation's efforts to combat influenza. One of WHO's 11 H5 Reference Laboratories was located in the Russian Federation. It had been working on diagnosis of H5 influenza since 2009 and was a candidate to become a WHO Collaborating Centre for Influenza.

Dr BIRINTANYA (Burundi), speaking on behalf of the Member States of the African Region, said that from the moment the first confirmed case of influenza A(H1N1) had been detected in the Region, in June 2009, until the end of the pandemic in August 2010, 36 000 cases, 267 of them fatal, in 35 Member States had been confirmed by laboratories. The pandemic had exposed the Region's limited capacity for dealing with such an emergency: few laboratories had been able to confirm cases, and only two countries had had access to influenza vaccines. Currently, however, diagnosis had been improved, surveillance had been strengthened, and 38 countries had developed vaccine-deployment plans and had immunized up to 10% of their populations. He acknowledged gratefully the international solidarity that had emerged during the pandemic. The lessons learnt must be retained and reinforced; to that end informal groups had been set up, in particular on the Nagoya Protocol, conflict resolution and terminology. Efforts to strengthen national diagnostic capacities should be pursued, transboundary surveillance and collaboration maintained and enhanced, influenza vaccine coverage extended through greater accessibility of influenza vaccines, and implementation of the International Health Regulations (2005) accelerated.

Dr REN Minghui (China) welcomed the fact that, despite divergent views, progress had been made in the negotiations. All countries should participate in the meeting of the Open-Ended Working Group due to be held in April 2011 in a pragmatic and flexible manner and with a strong sense of responsibility. Intellectual property rights should not prevent the resolution of public health issues. Recipients of biological material outside WHO should bear the responsibility for benefit sharing. Developed and developing countries had different responsibilities and should not be treated in the same way. Due account must be taken of production and supply capacity, needs and mutual advantage. In 2010 China's National Influenza Centre had become a WHO Collaborating Centre for Influenza. China had established a surveillance network comprising 411 network laboratories and 556 sentinel hospitals. The Government was prepared to strengthen exchanges and cooperation with international organizations and Member States with a view to enabling the National Influenza Centre to play its full role as a WHO Collaborating Centre.

Dr PÁVA (alternate to Dr Kökény, Hungary), speaking on behalf of the European Union, said that the Union was fully committed to finding agreement during the negotiations before the Sixty-fourth World Health Assembly. It was important for industry to engage in intersessional discussions with the co-chairs and to be available for consultation at the meeting of the Open-Ended Working Group in April 2011. The technical studies to be provided by WHO and the results of consultations with stakeholders by the co-chairs and of the efforts of the working groups should all be available before that meeting.

Professor HAQUE (Bangladesh) noted that the current system needed to be changed and expressed the hope that the negotiations would produce a sustainable solution, injecting greater equity and transparency into the process. The preliminary drafts of the technical studies conducted by WHO had helped to identify existing gaps and had put forward target scenarios for the future; the final versions should present the most viable and cost-effective options.

The recently concluded Nagoya Protocol recognized the principles of access and benefit sharing on an equal footing, and the pandemic influenza preparedness negotiations should adhere to those

principles. Sufficient predictability and accountability in the access and benefit-sharing arrangements were required: the current ad hoc arrangements entailed a donor-centric approach. He favoured the use of legally enforceable contracts, both within and outside the WHO network, for the transfer of clinical specimens or influenza viruses derived therefrom. The co-chairs' consultations with industry stakeholders should promote greater understanding in that area, and relevant civil society organizations should be invited to give their comments.

He thanked WHO for supporting his Government's establishment of an advanced medicine and vaccine testing laboratory. Further technical and financial assistance would help Bangladesh to become one of the first least-developed countries with the capacity to produce influenza vaccines at an affordable price.

Mr LARSEN (Norway) said that pandemic (H1N1) 2009 had demonstrated the vital importance of a well-functioning influenza-surveillance system providing updated assessments to public health authorities. The experience with vaccine deployment by WHO during the recent pandemic had revealed the need for a predictable and more equitable preparedness and response system; hence the importance of reaching agreement on the Pandemic Influenza Preparedness Framework. Significant progress had been made at the meeting of the Open-Ended Working Group in December 2010; that momentum must be maintained so as to finalize the work at the forthcoming meeting in April 2011. Irrespective of whether agreement was reached at that meeting, however, WHO must continue its important work to increase vaccine-production capacity and implement other agreed measures in order to strengthen pandemic preparedness and response.

Ms BILLINGS (Canada) said that the negotiations in December 2010 had been a positive step towards finalizing the Pandemic Influenza Preparedness Framework. She welcomed the work done by WHO to provide more detailed information in support of the discussions in the Open-Ended Working Group. The technical studies had been instrumental in enabling Member States to recognize the complexity of capacity building for pandemic influenza preparedness and response and the need to consider the linkages between the Framework and mechanisms such as the Global Pandemic Influenza Action Plan to Increase Vaccine Supply. Member States had an opportunity to build on the work done and to focus on tangible results furthering global preparedness. The technical studies must be finalized rapidly in order to facilitate the deliberations in April 2011. Canada was committed to furthering the discussions with the objective of reaching a conclusion as soon as possible.

Dr OMI (Japan) said that all persons should have access to safe, affordable and effective vaccines, but the hard reality was that many in the developing world did not. Developing countries had been working to strengthen their national capacity to make vaccines available to their populations, and developed countries had given them strong support in terms of technical and financial resources. For example, his country had provided about US\$ 10 million in response to calls from the Director-General for support for developing countries.

Much energy and time and many resources had been devoted to discussion of the difficult subject of sample and benefit sharing, sometimes at the expense of other important public health issues like maternal and child health. Certainly, some progress had been made but, overall, countries seemed to be entrenched in their positions. However, the time had come to reach consensus. One practical arrangement that might be considered was a voluntary contribution by manufacturers of specific percentages of their profits from selling seasonal influenza vaccine and pandemic influenza vaccines, as had been proposed by the European Union. The size of the percentage and other specific requirements could be discussed at the forthcoming Open-Ended Working Group meeting.

Mrs FARANI AZEVÊDO (adviser to Dr Buss, Brazil) said that the outbreak of pandemic (H1N1) 2009 had revealed the need for a better balance between two obligations: to share viruses and to share the benefits of work done with them. Viruses had been shared rapidly during the pandemic so as to enable vaccines to be produced, but the benefits had not been shared equally between national health systems, to the particular disadvantage of developing countries. The global lack of capacity to

produce benefits in a timely and efficient manner needed to be addressed. The future framework must cover facilitated access to vaccines, antiviral medicines and diagnostic kits and greater capacity of developing countries to produce them.

Some signs of convergence on core issues had emerged at the most recent meeting of the Open-Ended Working Group. Participants in the next round of negotiations had the duty to arrive at concrete results to ensure that lives were not lost owing to an unfair and unequal system. The Secretariat and other Member States must listen to the voices of developing countries that were eager to be part of the solution. Donations of vaccines were much needed, but diversification and increased production of vaccines by industry would also help to carry out the mandate of the Organization, which was to save the lives of people whose health was endangered.

Dr DAULAIRE (United States of America) said that the matter went to the heart of WHO's mandate. His Government strongly supported the Global Influenza Surveillance Network, a critical tool for risk assessment, global response and capacity building to prepare for influenza epidemics and pandemics. The rapid and open sharing of influenza viruses remained central to global preparedness and response, as had been highlighted by pandemic (H1N1) 2009. He acknowledged the concern of several Member States regarding access to pre-pandemic and pandemic vaccines and the desire for greater access to benefits. Considerable areas of consensus had emerged in negotiations in the Open-Ended Working Group, and those must be exploited. Endorsing the comments made by the member for Brazil, he said that all Member States should concentrate on developing strategies to increase manufacturing capacity for influenza vaccine in developing countries. The United States was committed to that effort: his Government had already contributed significant resources in support of WHO's Global Pandemic Influenza Action Plan to Increase Vaccine Supply and had made a sizeable contribution of vaccine to WHO's vaccine pool.

Mr YUSOF (Brunei Darussalam) said that generally the morbidity and mortality rates during the recent pandemic (H1N1) 2009 had not been as high as had originally been feared. The pandemic's legacy did, however, provide an opportunity to prepare responses to the threat of future emerging diseases. The gravity of the threat of the pandemic had understandably led to responses that appeared severe or inappropriate; hence the need for a review, based on the experience gained. For example, risk communication needed to be refined and adapted according to the stage of the pandemic in a given region or Member State. Timely access to vaccines and poor vaccine uptake also needed close examination, as they were significant elements in outbreak and pandemic management. The Secretariat should develop innovative approaches to provide support to Member States in preparing for other threats.

Mrs HANJAM DA COSTA SOARES (Timor-Leste), observing that all regions of the world had been affected, highlighted the need for access to affordable vaccines, availability of vaccines and antiretroviral medicines, laboratory capacity building, and clear and timely emergency preparedness. Intellectual property commitments must be respected.

Ms CREELMAN (Australia)¹ said that, although some challenges still had to be addressed, the Pandemic Influenza Preparedness Framework and the Standard Material Transfer Agreements needed to be finalized at the Open-Ended Working Group meeting in April 2011. Australia was committed to contributing to the successful conclusion of the negotiations.

The DIRECTOR-GENERAL said that members' comments amounted to a unanimous chorus of commitment to completing the negotiations. She invited Member States to send high-level delegations to the April 2011 meeting to ensure that those negotiations were completed. Much remained to be

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

done before the meeting, however. The co-chairs were to conduct in-depth consultations with civil society and industries throughout the world. WIPO had been enlisted to help with the intellectual property search. Australia, Brazil and India had been asked to take on additional tasks. The Secretariat was working to complete technical studies in order to facilitate deliberations. However, the request from the member for India that they should be made available two months in advance of the April meeting could not be accommodated owing to lack of time. All the preparations for the meeting should be conducted thoroughly and rigorously, so as to ensure success, but the main ingredient for success was political will.

The Board noted the report.

Implementation of the International Health Regulations (2005): Item 4.2 of the Agenda (Documents EB128/5 and EB128/5 Add.1)

The CHAIRMAN, drawing attention to the reports, said that in paragraph 18 of some language versions of document EB128/5 the word “disinfection” should be replaced by “disinsection”. The correction had been made to the electronic version of the report.

Dr FINEBERG (Chair of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009), referring to the report contained in document EB128/5 Add.1, outlined the progress made by the Review Committee in its two tasks: assessing the functioning of the International Health Regulations (2005) in general and with specific reference to pandemic (H1N1) 2009; and reviewing the scope of efforts and performance of the Secretariat and Member States in the face of pandemic (H1N1) 2009. At its three meetings in 2010, the Review Committee had heard from various parties involved in implementing the International Health Regulations (2005) or responding to pandemic (H1N1) 2009, and after each meeting it had adopted an interim report that had been submitted to the Director-General and posted on the WHO web site. The Committee was working on a preliminary document setting out its main findings, conclusions and recommendations, which would be transmitted to Member States before its fourth meeting, planned for 28 to 30 March 2011. Member States would be able to discuss the document at the fourth meeting; their input would be used in the Committee’s final report, to be submitted to the Director-General for transmission to the Sixty-fourth World Health Assembly.

Throughout its work, the Committee had aimed to be systematic, open, objective and fair, and had striven to rely on evidence presented to it or identified from available sources. It had been provided with access to internal Secretariat documents. The members of the Committee had been deeply engaged in the thorough process undertaken. Its conclusions and recommendations would respond to the challenge of outlining steps to prepare the world for future public health emergencies, in line with the aims pursued by the Board.

Dr LUKWAGO (Uganda), speaking on behalf of the Member States of the African Region, noted with appreciation the work of the Review Committee and looked forward to the comprehensive report to be submitted to the Sixty-fourth World Health Assembly. Recognizing WHO’s role in providing support to countries in order to meet the core capacity requirements of the International Health Regulations (2005), he said that Member States in the Region needed more support for strengthening laboratory capacity, improving centres of excellence and sustaining existing networks, such as the African Field Epidemiology Network.

He recalled the fifty-sixth session of the Regional Committee for Africa at which States Parties to the International Health Regulations (2005) had emphasized the need to focus on their implementation in the context of the Integrated Disease Surveillance and Response Strategy.¹ Most

¹ See document AFR/RC56/24, paragraphs 190 and 191.

African countries were in the process of developing minimum core capacities for surveillance and response, although challenges remained with regard to strengthening points of entry.

The Member States in the Region had made considerable progress in implementing the Regulations, but faced difficulties in complying with annual reporting requirements, mobilizing funds to support implementation, assessing core capacities and ensuring timely notification of events constituting a public health emergency of national or international concern. It was important to note that priority diseases varied across regions, and regional approaches to disease surveillance should therefore be embraced, which required regional collaboration in implementing the Regulations. He welcomed WHO's support in strengthening such collaboration.

Professor HOUSSIN (France) expressed the hope that the Review Committee would recommend actions in the areas already identified for improvement. The report contained in document EB128/5 demonstrated that efforts to strengthen national capacities in accordance with Annex 1 of the Regulations, particularly with regard to laboratory capacity and points of entry, should be continued. The necessary tools for coordinated implementation, including guidance on preparing emergency public health plans for ports and airports, inspecting vessels, and taking anti-vector measures at points of entry, should be made available to Member States as soon as possible. The Secretariat should also increase its technical support for countries requesting assistance in capacity building, in which the role of the regional offices, in conjunction with the International Health Regulations Coordination WHO Lyon Office, was vital. He expressed particular interest in the results of work on country-specific mapping of yellow fever risk and in the preparation of a list of countries needing disinsection for departing conveyances, for which purpose a detailed study should be undertaken analysing risk by point of entry, rather than by country, and covering other vector-borne diseases. If relevant goals were to be met by 2012, Member States must introduce the tools provided for in the Regulations quickly, and he expressed appreciation for WHO's support to that end.

Dr DAULAIRE (United States of America) said that the International Health Regulations (2005) should be universally applied for the good of the international community. All States Parties must meet their obligations under the Regulations by openly and transparently sharing information about outbreaks of disease and complying with other requirements. He encouraged WHO to work with States Parties in order to further enhance the utility and usability of information-sharing systems and ensure that they remained secure.

Sustainable systems to develop, enhance and maintain core competencies in disease detection, laboratory diagnosis and disease control were essential to the successful and timely implementation of the Regulations. For example, investments in the Global Influenza Surveillance Network had paid dividends in tackling pandemic (H1N1) 2009, and national pandemic preparedness plans and response efforts, developed under the guidance of WHO, had enabled the Secretariat and Member States to limit the global impact of the outbreak, partly through an unprecedented level of international cooperation.

Complete, universal and timely implementation of the Regulations would require the collaboration and assistance outlined in Article 44 thereof, and he encouraged WHO to continue to work closely with States Parties to identify areas of need for countries with limited resources and opportunities to address those needs. The ability to monitor progress in implementation accurately was crucial for WHO and individual States Parties. WHO must have an accurate picture of the status of implementation at global and regional levels; each State Party must be able to monitor its own progress at national and subnational levels; and WHO should work with States Parties to identify and address impediments to completing and submitting the annual reports required under the Regulations.

Mr HAGE CARMO (adviser to Dr Buss, Brazil) said that the countries of South America had treated implementation of the International Health Regulations (2005) as a priority, in collaboration with PAHO, and would continue their efforts to build their core capacities to detect and respond to public health emergencies, along with other activities aimed at ensuring full implementation of the Regulations. Health ministers from the countries of the Southern Common Market (MERCOSUR) had signed an agreement in November 2010 to continue prioritizing implementation activities and had

demonstrated their commitment to monitoring global implementation. The issue had also been discussed at a meeting of representatives of the Union of South American Nations (UNASUR) in December 2010. The MERCOSUR health ministers had requested WHO to conclude its revision of indicators for implementation of the Regulations, drawing on the experience of countries, subregions and regions in using indicators, which should be submitted to the Sixty-fourth World Health Assembly. Given the time constraints involved, WHO should initiate regional consultations with all States Parties in order to prepare a harmonized instrument for assessing global implementation, incorporating regional contributions, by 2012.

Dr MOHAMED (Oman), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that global partnership had strengthened international efforts to respond to pandemic (H1N1) 2009, for example through timely reporting of cases and high levels of transparency in the Region. Meeting the broad scope of the International Health Regulations (2005) required time, commitment and a desire for change. Drawing on their experiences in how the Regulations had functioned during pandemic (H1N1) 2009, the countries of the Region fully supported the Secretariat's activities to review their responses and assist them in achieving the required minimum core capacities, including those related to surveillance and response, public health laboratories, points of entry, and logistics and supplies.

The Secretariat's continued efforts to support Member States in the Region in assessing their core capacity requirements and monitoring progress in developing those capacities were appreciated, and renewed action by the Secretariat, including identifying the necessary technical and financial support, was needed if the Regulations were to be fully implemented by the deadline of 14 June 2012. Countries needed to evaluate how the Regulations had functioned during pandemic (H1N1) 2009. In addition, countries planning to revise their national public health laws, an obligation for successful implementation of the Regulations, needed support, and countries with special needs should remain a priority. Urgent action was required in that regard, before any unexpected incident could occur.

Mrs GIDLOW (Samoa) expressed continued appreciation and support for the technical guidance provided by the International Health Regulations (2005) and for the work of WHO during the testing time of pandemic (H1N1) 2009. Samoa's support for WHO's work in implementing the Regulations was based on its experience of the influenza pandemic of 1918 and the fact that its population was small and vulnerable.

Mr LARSEN (Norway) stressed the importance of a rigorous review of the International Health Regulations (2005) process, including assessment of the handling of pandemic (H1N1) 2009, particularly in view of the emphasis many countries had placed at that time on advice provided by WHO. Pandemics were rare, and were seldom dealt with by leaders with prior experience. Even a mild pandemic could create or weaken trust in national health authorities. Both they and WHO should demonstrate willingness to submit to transparent and critical evaluation of all aspects of performance during pandemic (H1N1) 2009. It was therefore unfortunate that the report of the Review Committee had not been submitted to the Board at its current session, and he requested an indication from the Review Committee of its findings. He looked forward to receiving the report, as Norway would use lessons learnt by the international community, along with its national experience, in its current work to revise its national pandemic plan.

Dr MELNIKOVA (adviser to Professor Starodubov, Russian Federation) said that the Director-General's reports provided a clear overview of the development of core capacities among States Parties. Her country continued to develop its national capacity to respond to emergency situations of international concern, harmonizing its legislation, training staff, strengthening laboratory capacity, and improving epidemiological surveillance and sanitation. She expressed support for WHO's activities in the area of emergency preparedness, particularly with regard to provision of information, and suggested that more information on potential public health emergencies should be made available through the WHO web site. Guidance on implementing the Regulations should be

made available in all WHO's official languages. It would be useful for Member States to receive information on actual and potential emergency situations of international concern that had occurred in recent years, such as outbreaks of infectious diseases and toxic hazards. She echoed requests for clarification of the procedure for transport certification and informing port authorities about health measures for vessels. Steps should be taken to harmonize procedures for exempting vessels from health inspection; the Russian Federation would participate in such activities. Global partnership, in which WHO should play a key role, was vital in implementing the Regulations.

Dr REN Minghui (China) commended the work done to implement the Regulations, which had contributed significantly to ensuring an effective response to and mitigation of the effects of public health emergencies. The final report of the Review Committee should help to strengthen implementation and inform future efforts to control pandemics. The assessment of core capacity gave cause for concern. Building core capacities should be an important component of strengthening national health systems, and WHO should mobilize and coordinate international resources to support such capacity building in developing countries as an important component of international health system development.

Mr CHANDRAMOULI (India) said that developing countries were unlikely to attain the high level of performance in core capacities required under the International Health Regulations (2005) by the deadline of 2012. His Government had taken various steps to implement the Regulations, including designating IHR focal points at national and regional levels, drafting a new public health bill to replace the existing legislation, which dated from 1897, and revising public health rules for ports and aircraft.

Dr OMI (Japan) welcomed the improved response to the self-assessment questionnaire from States Parties to the Regulations compared with the previous biennium, but noted that some States Parties had failed to meet the core capacity requirements. He asked the Secretariat to analyse the reasons for that failure and make proposals to remedy the situation.

Based on WHO's figures, the mortality rate from pandemic (H1N1) 2009 had been lowest in Japan. Subsequent analysis had identified three contributory factors: extensive closure of schools, particularly in the early stages of the outbreak; easy access to medical services for treatment and diagnosis; and high levels of public awareness and hygienic practice. He encouraged the Review Committee to take note of Japan's experience in its final report.

Dr ST JOHN (Barbados) reaffirmed that her Government remained committed to full implementation of the International Health Regulations (2005). Its actions included drafting protocols for the transfer of ill air and sea passengers to health-care facilities, taking measures to improve food handling, monitoring potable water supplies and awareness raising, and giving specific training to port health officials, in collaboration with PAHO and ICAO. Quarantine centres had been established at the two main points of entry; vector-control activities at points of entry had been strengthened; and food establishments at points of entry were monitored. Technical assistance from PAHO had been sought for integrating the Regulations' obligations into national legislation, and ICAO had helped to organize a workshop to facilitate assessment of port health and other core capacities at the international airport. The national influenza surveillance system had been revised and made more comprehensive. Pandemic (H1N1) 2009 had resulted in greater laboratory, political and medical involvement in surveillance, and clinical surveillance had been expanded to cover all public health facilities, which now reported weekly to the epidemiology unit. PAHO risk-communication strategies were in regular use.

Mr HAZIM (adviser to Mr El Makkoui, Morocco) said that pandemic (H1N1) 2009 had provided an opportunity to test the International Health Regulations (2005) and learn lessons from their application; in general the Regulations had proven to be effective. Even though the international community was better prepared for future public health events, the need to improve communication remained paramount. The Review Committee should make recommendations in that regard,

particularly in view of the problems experienced during pandemic (H1N1) 2009. Consideration should be given to how the various stages of a pandemic were defined, for instance by taking into account virulence. The technological tools used should also be evaluated. Many countries had been unable to ensure appropriate follow-up and would not meet the deadline of 2012. What support could WHO or other bodies provide to assist them? Morocco had invested resources in implementing the Regulations.

Dr JADUE (Chile) reaffirmed her country's commitment to the International Health Regulations (2005), which had enabled many countries to improve their core capacities, with valuable lessons learnt. Chile had established various national centres, providing an organized framework for response that had been tested both by pandemic (H1N1) 2009 and the earthquake that had hit the country in 2010. Nevertheless, further refinements to national and international public health approaches were needed so that they conformed with the Regulations. In order to improve preparedness for and response to potential pandemics and other public health emergencies, WHO should exercise stronger leadership and provide guidance and information in real time to allow countries to take more appropriate decisions. In addition, clearer definitions of levels of alert and criteria for identifying the stages of pandemics should be formulated.

Dr ALI (alternate to Professor Haque, Bangladesh) said that national IHR focal points in the South-East Asia Region had functioned well during pandemic (H1N1) 2009 and that progress had been made in strengthening core capacities. The International Health Regulations (2005) had come into force in Bangladesh in 2007 and the country complied with its responsibilities to report public health emergencies to WHO. A national strategy and guidelines for reporting public health emergencies of international concern had been drafted, and implementation of the Regulations was assessed regularly.

Despite the progress reported, country capacities remained insufficient to handle issues such as the threat from the various circulating strains of influenza virus or the urgency of emerging and re-emerging diseases of international public health concern. Neither was laboratory capacity sufficient for diagnostic purposes, and financial, human and material resources in the health sector were inadequate. Developing countries like Bangladesh found it difficult to counter misleading and unscientific media reports. He recommended that the Secretariat mobilize more resources to assist Member States in further developing their capacities to a level that provided the best possible protection.

Dr FINEBERG (Chair of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009), responding to comments, said that, although the Committee's final report was not yet available, a preliminary version would be discussed at its fourth meeting, in March 2011, thereby providing more time for discussion of the issues involved and obtaining input from all States Parties. The rules establishing the Review Committee provided for a minority report if consensus could not be reached among its members. He assured the Board that the Committee's report would be critical and transparent, and would seek to guide future decision-making in an honest manner. Some of the issues raised by members of the Board would be covered in the final report. It would not assess individual countries' policies and performance, but draw lessons.

The CHAIRMAN welcomed the balanced approach pursued by the Review Committee.

Dr FUKUDA (Assistant Director-General) reviewed the main themes that had been raised by members. The experience of pandemic (H1N1) 2009 had underscored the importance of the International Health Regulations (2005), which should be strengthened. Concern had been expressed that some States Parties would have difficulty in enhancing their core capacities sufficiently to meet the deadline of June 2012 and the Secretariat had been asked what action it could take in that regard. That deadline was the first to occur under the Regulations; a semi-automatic process allowed for requests for a two-year extension, which should provide some room for manoeuvre.

In terms of providing additional guidance and tools, the Secretariat would work closely with Member States to identify the most important and cost-effective areas for action, such as ensuring that information was made available promptly in all official languages. The Secretariat would study the reasons why some States Parties were having difficulty in meeting deadlines for developing core capacities and taking appropriate action. It would also enhance coordination for core capacity building as an international activity. He acknowledged the need to undertake harmonization work in preparing the next self-assessment questionnaire, one means being through regional consultations.

The DIRECTOR-GENERAL expressed appreciation to the Review Committee and its Chair for their hard work, and stressed the independence of the Committee, which had been provided with full access to internal WHO documents.

The Board noted the reports.

Public health, innovation and intellectual property: Consultative Expert Working Group on Research and Development: Financing and Coordination: Item 4.3 of the Agenda (Document EB128/6)

The CHAIRMAN drew attention to the report, which proposed a list of members of the Consultative Expert Working Group on Research and Development established in accordance with resolution WHA63.28.

Dr KIENY (Assistant Director-General) announced a correction to the report: for the Regional Office for South-East Asia, the Secretariat wished to nominate Mr Goyal of India instead of Mr Rannan-Eliya of Sri Lanka. Mr Goyal was Additional Secretary and Director-General in the Department of Health and Family Welfare of India, specializing in health policy and financing.

Dr PÁVA (alternate to Dr Kökény, Hungary), speaking on behalf of the European Union, emphasized the importance of scientific integrity and expressed the hope that the deliberations of the Consultative Expert Working Group would be free from conflict of interest. She endorsed the list of proposed members of the Group, who had been selected in a transparent manner based on regional representation and professional profile. The Group should proceed with its work in a spirit of cooperation and collaboration, keeping in mind the importance of considering, within its mandate, how best to implement the global strategy and plan of action on public health, innovation and intellectual property. She asked when the first meeting of the Group would be held.

Dr OULD HORMA (Mauritania), speaking on behalf of the Member States of the African Region, said that health-related research and development was inadequate. Less than 5% of funding was allocated to diseases that particularly affected developing countries. Current international and national rules on intellectual property rights, especially the strict protection of intellectual property in pharmaceutical markets, did not facilitate access in the Region to affordable products. Priority should be given to allocating sufficient, sustained resources to research and development aimed at public health and needs relevant to diseases disproportionately affecting developing countries; and improving access to affordable health products.

He reviewed the steps taken by the governing bodies that had led to the adoption of the global strategy and plan of action on public health, innovation and intellectual property. In October 2008 the African Network on Drugs and Diagnostics Innovation had been launched in order to promote and support African innovation in health products and resolve public health issues in Africa. In 2009 the Regional Committee for Africa at its fifty-ninth session had requested the Secretariat and its partners to support countries in implementing the global strategy and plan of action. At the 126th session of the

Executive Board, members for Member States of the African Region had stressed the need for faster action by all within the framework of the global strategy and plan of action,¹ and WHO had been invited to collaborate with WIPO and WTO to organize high-level consultations with major donors and stakeholders.

At the fifth meeting of the African Network on Drugs and Diagnostics Innovation working group, held in January 2010, agreement had been reached on a strategy covering, in particular, funding, intellectual property, and advocacy and communication. WHO and the African Development Bank had been invited to work with partners to hasten the creation of an African innovation fund. A key element of the strategy was to establish national research and development networks so as to ensure that existing capacity was used and that research and development programmes were tailored to local priorities. The legal basis for the fund was almost finalized. The biggest remaining challenges were the lack of established structures to ensure coordination between stakeholders, and Member States' limited financial and human resources for identifying priorities and following the global strategy and plan of action on public health, innovation and intellectual property.

He welcomed the proposed composition of the Consultative Expert Working Group on Research and Development.

Mrs ESCOREL DE MORAES (adviser to Dr Buss, Brazil) said that the global strategy and plan of action on public health, innovation and intellectual property aimed to promote new thinking on innovation and access to medicines and to provide a framework for securing an enhanced and sustainable basis for essential health research and development relevant to diseases disproportionately affecting developing countries. She recalled that the Sixty-third World Health Assembly had deemed the results achieved by the previous Expert Working Group to have been unsatisfactory and incomplete. The Consultative Expert Working Group on Research and Development established by resolution WHA63.28 should contribute to a more equitable, inclusive and fair global health system. It should not hesitate to break new ground, and must consider all proposals, including the de-linkage of research and development costs and the price of health products.

She would have appreciated access to the list of 79 experts proposed by Member States, a more thorough description of the selection procedure, an explanation of how the chair of the Group would be selected, and information on its working methods and meeting dates. It would also have been useful for the curricula vitae of the experts to have been made available to the Board.

All Member States should follow the work of the members of the working group closely. Those members must abide strictly by the Organization's policy on conflict of interest, should be present at all meetings and participate in discussion of all issues. She expressed disappointment at the lack of reporting on the implementation of the global strategy and plan of action, both in terms of work done and plans for 2011. It was to be hoped that the lack of a report did not imply lack of progress.

Ms BILLINGS (Canada), noting the complex and rapidly developing nature of research and development financing, said that Canada had contributed significant amounts in recent years to support research for solutions to global health challenges, including US\$ 200 million to support an advance market commitment for a pneumococcal vaccine, and would continue to consider new, innovative financing proposals on a case-by-case basis. She welcomed the creation of the new Consultative Expert Working Group, the calibre of whose proposed experts was encouraging. In order to move beyond work previously done, the Group, in its analysis of financing mechanisms, should bear in mind that a given mechanism might not be appropriate for all products because of differences in the state of research and development, market conditions, and regional needs and priorities. The Group's proposals should be practicable and include the national and international actions that would be needed to apply them. She supported the proposed list of experts.

¹ See document EB126/2010/REC/2, summary records of the second, third, fourth and fifth meetings.

Mr HOHMAN (alternate to Dr Daulaire, United States of America) welcomed the inclusive approach to preparing the list of experts but disagreed with the statement by the member for Brazil that the Health Assembly had found earlier work on the issues inadequate: although some delegations had expressed dissatisfaction, others had supported the results achieved by the previous working group. He expressed concern about the unprecedented decision for the Board to review the composition of a working group; it should not set a precedent. He stressed that the Working Group must respect its mandate.

Mr YUSOF (Brunei Darussalam) underlined the importance of the Consultative Expert Working Group and the relevance of health research at all levels for strengthening and planning health-care systems, delivery and structure, and for formulating policy to achieve sustainability and universal coverage. Research and development should be pursued and strengthened, based on the priorities of achieving research outcomes that would improve global health and promoting innovative approaches. He supported the proposed list of experts.

Dr ALI (alternate to Professor Haque, Bangladesh) requested that the curricula vitae of the list of experts be circulated to the Board, with due respect for privacy, and that the Board's attention be drawn to any potential conflict of interest. The candidates to be endorsed by the Board should be beyond reproach, in order to forestall any future controversy. The Working Group should develop its terms of reference to allow for the inclusive participation of all members in the consultation process. Its report should be based on consultation with relevant stakeholders and reflect diversity of views in its recommendations, so as to give Member States the opportunity to make informed choices. The Group should take careful note of Member States' discussions of the previous report on the subject.

Dr VIROJ TANGCHAROENSATHIEN (Thailand),¹ endorsing the statement made by the member for Brazil, questioned the suitability of an employee of a major pharmaceutical company for membership of the Working Group, despite his impressive experience and skills. In order to avoid any possibility of a conflict of interest, that individual could be invited to participate other than as a member in the work of the Group. He further expressed concern at the balance of areas of expertise among the candidates, most of whom were public health specialists. The Group should not be dominated by technical experts.

Dr NARVÁEZ (Ecuador) echoed the comments made by the member for Brazil. Member States should be informed promptly about the mechanisms used to deal transparently with potential conflicts of interest. Any recommendation made by the Working Group must take into account the need for the results of innovation to be made accessible to all, especially patients in resource-constrained developing countries.

The DIRECTOR-GENERAL said that the Secretariat had diligently followed the selection process agreed by the Health Assembly. Finding appropriate candidates was a difficult task, and she expressed the view that experts from the pharmaceutical industry should not necessarily be excluded, provided that all interests were duly declared. Member States would be able to monitor the work of the Working Group. If any members of the Group acted in a manner that was not balanced and transparent, steps could be taken to rectify the situation.

Dr KIENY (Assistant Director-General) assured the Board that the highest level of scientific integrity was sought from members of the Working Group and that the Secretariat would analyse and deal with any conflict of interest that might be revealed. A summary of the curricula vitae and declarations of interest of candidates for membership would be made available to the Board; however,

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

dates of meetings could not be set until the membership had been finalized. She expressed the view that the Working Group would benefit from the input and unique experience of the expert proposed from the pharmaceutical industry. His industrial background was clear, but the views and approaches of industry could be of use and interest to the Group.

The CHAIRMAN invited the Board to take note of the report and approve the list of experts proposed for membership of the Consultative Expert Working Group.

Mrs ESCOREL DE MORAES (adviser to Dr Buss, Brazil), rising to a point of order, echoed the concern expressed by the representative of Thailand and requested that no decision be taken until the Board had considered the issue further. Even if the Working Group could and should invite representatives of industry to participate in its work, they should not serve as members of the Group.

The CHAIRMAN said that further consideration of the issue would be deferred to a later meeting.

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

The meeting rose at 17:55.

THIRD MEETING

Tuesday, 18 January 2011, at 09:10

Chairman: Dr M. KÖKÉNY (Hungary)

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

Public health, innovation and intellectual property: Item 4.3 of the Agenda (Document EB128/6) (continued)

Ms ESCOREL DE MORAES (adviser to Dr Buss, Brazil) recalled that during the previous meeting she had asked about the implementation of the Global strategy and plan of action on public health, innovation and intellectual property. She suggested that the Secretariat should be allocated a time during the session to make a brief presentation on the work done during 2010 and on plans for the future.

The CHAIRMAN said that the Secretariat would have the opportunity to make a presentation later in the session.

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

2. MANAGEMENT MATTERS: Item 8 of the Agenda

Election of the Director-General of the World Health Organization: Item 8.1 of the Agenda (Document EB128/27)

The CHAIRMAN said that he did not propose to open the item for substantive discussion at the present time, but rather wished to invite the Board to consider establishing a drafting group with a view to reaching consensus following submission of a draft resolution on the Rules of Procedure for the appointment of the Director-General of the World Health Organization, proposed by Burundi on behalf of the Member States of the African Region, and a draft decision on the election of the Director-General of the World Health Organization, proposed by Barbados, Canada, Monaco, Norway, Switzerland and the United States of America.

Rules of Procedure for the appointment of the Director-General of the World Health Organization

The Executive Board,

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

The Sixty-fourth World Health Assembly,
PP1 Having regard to the Constitution of the World Health Organization, in particular Articles 30 to 37;

PP2 Recalling the Rules of Procedure of the World Health Assembly and the Rules of Procedure of the Executive Board relating to the appointment of the Director-General;

P3 Taking note of the report of the Secretariat on the election of the Director-General of the World Health Organization contained in document EB128/27;

PP4 Stressing the imperative need for further strengthening of the guarantees of transparency and equity among the six geographical regions of the World Health Organization in the process of nomination and appointment of the Director-General of the Organization;

PP5 Recognizing that the issue of the nomination and appointment of the Director-General of the World Health Organization has been under active review since 2006 within the relevant bodies of the Organization;

PP6 Reaffirming the continued relevance of the criteria which should be met by the candidate for the post of Director-General, as adopted by the Executive Board in its resolution EB97.R10;

PP7 Inspired by the practice observed in terms of geographical rotation for similar functions within the specialized agencies of the United Nations system, and informed by the moral conscience for principles of equity and equality,

1. APPROVES the principle of geographic rotation of the post of Director-General among the six regions of the World Health Organization;
2. REQUESTS the Executive Board to establish the modalities of implementation of paragraph 1 above and to recommend amendments to the existing procedures for the nomination and appointment of the Director-General;
3. FURTHER REQUESTS the Executive Board to report on the implementation of the present resolution to the Sixty-fifth World Health Assembly.

Election of the Director-General of the World Health Organization

The Executive Board,

PP1 Guided by the Purposes and Principles of the Charter of the United Nations;

PP2 Recalling the criteria set out in resolution EB97.10 concerning especially the competences/qualifications required for assuming the function of Director-General of the World Health Organization;

PP3 Recalling further the need to take into account adherence to the principle of equitable geographical representation and gender balance at **all** levels in the Secretariat, especially at headquarters, in order to improve its representative character;

PP4 Recognizing the need to address the concerns raised by Member States about the transparent, fair and equitable nature of the election process;

PP5 Having considered the report contained in document EB128/27:

1. DECIDES to establish a time-limited and results-oriented working group on the process of the election of the Director-General of the World Health Organization, composed by Member States and open to all Member States;¹

¹ And, where applicable, regional economic integration organizations.

2. REQUESTS the Director-General to convene and facilitate the work of the working group;
3. DECIDES that the working group will examine the following matters in the view of improving the process for the election of the Director-General of the World Health Organization:
 - (1) reviewing and analysing all the aspects of the nomination and of the appointment process of the Director-General;
 - (2) identifying points in the nomination and appointment process which could be improved;
 - (3) proposing possible ways for improving the overall process;
4. DECIDES that the working group shall report on its work in relation to the issues set out in paragraph 3 above for the consideration of the 130th Executive Board.

Dr OMI (Japan) said that, although there was unanimous agreement that the criteria laid out in resolution EB97.R10 continued to be valid and relevant, they did not appear to be sufficient to meet the concerns of some Member States with regard to the procedure for electing the Director-General. In order to allay those concerns, two key requirements must be fulfilled. First, all candidates must be able to compete on an equal footing. As long as a candidate met the criteria set out in resolution EB97.R10, he or she should have an equal chance of being appointed Director-General, regardless of the level of resources of his or her country. Secondly, the election process must be more transparent and open. One solution would be to develop a code of conduct for the election of the Director-General. Any discussion of such a code should take place before discussion of the question of regional rotation.

He acknowledged the concerns of some Member States regarding regional representation; however, it was essential that the best candidate be appointed to the post, and that might not happen under a system of regional rotation. A code of conduct for the election of the Director-General would benefit all regions and Member States, ensuring that the most qualified candidate was appointed, while enabling each region to put forward their most suitable candidates, thereby fostering greater regional representation in the post.

Dr BIRINTANYA (Burundi), speaking on behalf of the African Region, said that the procedure for the election of the Director-General was an issue of great importance for many African countries. The current merit-based procedure was not transparent and did not ensure equal opportunity for candidates from all regions. It was vital to reconcile merit and geographical representation. He therefore proposed that an additional criterion, that of rotation of the post among the six geographical regions of WHO, be incorporated into the criteria set out in resolution EB97.R10. That proposal was consistent with Article 31 of the Constitution and the practice of other organizations in the United Nations system; indeed the principle of geographical rotation was applied in the election of the Secretary-General of the United Nations. Geographical rotation would neither violate any legal provisions nor supplant the other criteria; candidates would still have to possess the requisite expertise and experience. He supported the Chairman's proposal to establish a drafting group and would be pleased to take part in its work with a view to reaching an equitable consensus.

Ms BILLINGS (Canada), expressing support for the establishment of a drafting group, recognized the benefits that geographical diversity brought to the United Nations system. Her country was committed to improving the election process in order to make it more transparent and equitable and to create a more level playing field for candidates from all regions.

Mr EL MAKKOU (Morocco) said that it was unfortunate that the outcome of the most recent discussions on the election of the Director-General, particularly those during the Sixty-third World Health Assembly, had not been reflected in the report. He did not oppose the criteria laid out in resolution EB97.R10, but sought to strengthen them with additional, complementary criteria in order

to increase the transparency and fairness of the election process. Consistent with the practice in other organizations in the United Nations system, the principle of regional rotation should apply to all senior-level posts at WHO and particularly to that of its highest technical and administrative official. Morocco was willing to work with other Member States to reach a consensus on the issue, and supported the establishment of a drafting group with a well-defined mandate and terms of reference.

Dr PÁVA (alternate to Dr Kökény, Hungary), speaking on behalf of the European Union, stressed the importance of appointing the best qualified candidate for the post of Director-General and that due regard should be paid to recruiting staff from all geographical regions. The election process had to be fair, democratic and transparent. The principles of merit-based selection and equitable geographical representation were not mutually exclusive. Enforcing geographical rotation for the post of Director-General, however, was not the best means of helping WHO to apply those two principles. Nevertheless, the European Union agreed that the recruitment process required further strengthening, particularly with regard to geographical representation.

For the moment, the Board's consideration of the matter should be limited to deciding whether to set up a drafting group. She favoured establishing a drafting group that should work on the basis of consensus and be open-ended, with participation open to representatives of all Member States. It should report to the Board at a subsequent meeting, at which time substantive discussion of the item could take place.

Dr DAULAIRE (United States of America), expressing support for the establishment of a drafting group, said that it was important that the procedure ensure equity and access for candidates from all regions. The suggestion of the member for Japan for a code of conduct had merit, and he requested the Legal Counsel to comment on that possibility.

Dr REN Minghui (China) said that merit, professional competency and geographical representation should be considered in equal measure. He would work with others in order to reach a consensus on the issue and supported the establishment of a drafting group.

Mr YUSOF (Brunei Darussalam) said that, although he understood the concerns of some members regarding geographical representation, for the benefit of WHO and the international community as a whole it was vital that the candidate who was the best qualified should be elected to the post of Director-General. He welcomed the suggestion of the member for Japan regarding a code of conduct and agreed that a drafting group should be formed to facilitate discussion of the issue.

Mr NEBENZIA (alternate to Professor Starodubov, Russian Federation) said that, although he could understand the reasons behind the proposal for geographical rotation of the Director-General post, changing the present approach would not necessarily be constructive and indeed might weaken WHO. It was important to take into account all the differing views, and he supported the establishment of a drafting group for that purpose, but was not prepared currently to support the idea of geographical rotation.

Dr BUSS (Brazil) said that technical competence must be the primary consideration. Candidates existed in all regions who were capable of filling the post of Director-General. It was important to ensure that in the debate all positions were heard and understood in order to find an equitable solution to the issue that was acceptable to all. To that end he supported the establishment of a drafting group and would participate in its deliberations.

Mrs GIDLOW (Samoa) aligned herself with the views of the members for Brunei Darussalam and Japan. The procedure for the election of the Director-General should be examined with a view to ensuring a fair and equitable selection based on merit and professional competency. She supported the establishment of a working group in order to reach consensus.

Mr CHANDRAMOULI (India) agreed that the post of the Director-General should be open to candidates from all regions; however, it was vital that the best candidate be elected. He supported the establishment of a drafting group.

Mr BABLOYAN (Armenia), expressing support for the establishment of a drafting group, said that it was essential to take an impartial and balanced approach to all issues within WHO, including the current subject. Although all regions had the right to propose candidates, he was concerned that enforcing a regional rotation cycle could lead to flawed decision-making.

Professor HAQUE (Bangladesh), expressing his support for the establishment of a drafting group, said that the election process for the Director-General should be looked at holistically. Any reform that was undertaken had to be far-reaching and sustainable and should ensure an equitable and transparent election process. The complex issue did not lend itself to a hasty solution. He favoured a time-bound, Member State-driven process for a closer examination of the systemic issues involved. It was to be hoped that the draft resolution to be developed by the drafting group would provide for such a process.

Mrs HANJAM DA COSTA SOARES (Timor-Leste), endorsing the views expressed by the members for China and India, outlined two options for the election of the Director-General: selection on the basis of regional rotation or selection on the basis of merit. She supported the establishment of a drafting group to examine those options.

Dr ALHAJ HUSSEIN (alternate to Dr Said, Syrian Arab Republic) stressed the importance of the criteria contained in resolution EB97.R10, in particular sensitiveness to cultural, social and political differences. He supported in principle the proposal for regional rotation as it would make the process more equitable.

Dr NARVÁEZ (Ecuador), expressing support for the creation of a drafting group, emphasized that technical ability and suitability for the post were fundamental criteria. However, regional rotation would ensure equal opportunities for all candidates.

Dr JADUE (Chile) recognized that merit, excellence and ability were the key criteria that should be applied when electing a Director-General. However, it was important that the concerns of all Member States and regions were taken into account. A drafting group should be set up to work towards consensus.

Mr BADR (Egypt)¹ stressed the need for constructive discussion in order to reach a fair and equitable agreement that was acceptable to all parties. The case for regional rotation had been well made. It was unacceptable that since 1947 three of the six regions had not had any chance of nominating a successful candidate to the post of Director-General. The time had come to look carefully at why that was and to take steps to ensure that the regional imbalance did not continue. Introducing the principle of regional rotation did not mean compromising on that of competence; the two principles were not mutually exclusive and indeed could be mutually supportive. He supported the establishment of a drafting group, but cautioned that the drafting group should be a means to facilitate discussion and reach consensus on the two draft proposals. Egypt, in its capacity as President of the Non-Aligned Movement, had organized a consultative meeting on the issue during January 2011. Several members of that Movement had expressed the need to establish a negotiating process to cover all aspects of the nomination and election of the Director-General. Such a process should have a

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

clearly defined mandate, objectives and timeframes. Members of the Non-Aligned Movement were keen to engage with all Member States with a view to building consensus.

The CHAIRMAN observed that it was generally agreed that the election process should be fairer and more transparent, although views differed on how to achieve that goal. He took it that the Board wished to establish a drafting group open to all Member States, and proposed that the group should be chaired by Dr Mohamed (Oman).

It was so decided.

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

3. TECHNICAL AND HEALTH MATTERS: Item 4 of the Agenda (resumed)

Health-related Millennium Development Goals: Item 4.4 of the Agenda (Document EB128/7)

The CHAIRMAN drew attention to a draft resolution on WHO's role in the follow-up to the high-level plenary meeting of the sixty-fifth session of the United Nations General Assembly on the review of the Millennium Development Goals (September 2010) proposed by Australia, Monaco, Norway, Senegal and Serbia, which read:

The Executive Board,

PP1 Having considered the report on health-related Millennium Development Goals;¹

PP2 Recalling resolutions WHA63.15 and WHA61.18 on monitoring of the achievement of the health-related Millennium Development Goals, and WHA63.24 on accelerated progress towards achievement of Millennium Development Goal 4 to reduce child mortality: prevention and treatment of pneumonia;

PP3 Expressing deep concern at the slow pace of progress in achieving Millennium Development Goals 4 and 5 on reducing child mortality and improving maternal health;

PP4 Welcoming the Global Strategy for Women's and Children's Health launched at the United Nations High-level Plenary Meeting of the General Assembly on the Millennium Development Goals (New York, September 2010) and acknowledging the strong political and financial commitment by Member States to follow up and implement the strategy;

PP5 Noting the Secretary-General's request that WHO leads a process to determine the most effective international institutional arrangements for global reporting, oversight and accountability on women's and children's health, including through the United Nations system;

PP6 Stressing that monitoring of resource flows and results are vital requirements in the management of national health plans;

PP7 Welcoming the establishment of the Commission on Information and Accountability for Women's and Children's Health, which consists of high-level representatives;

PP8 Noting that the objectives of the Commission are to:

(1) determine international institutional arrangements for global reporting, oversight and accountability on women's and children's health. This accountability framework will encompass results and resources, and identify the roles of the different partners involved;

¹ Document EB128/7.

- (2) identify ways to improve monitoring of progress towards women's and children's health while minimizing the reporting burden on countries, including a set of core indicators, efficient investment in data generation and better data sharing;
 - (3) propose actions to overcome major challenges to accountability at the country level, including strengthening of country capacity and addressing major data gaps such as the monitoring of vital events;
 - (4) identify opportunities for innovation provided by information technology that will facilitate improved accountability for results and resources, and propose ways of ensuring these opportunities are harnessed to bring maximum benefits to countries;
- PP9 stressing that aspects related to equity and rights should also be addressed;
- PP10 Stressing that the Commission should take into account relevant existing data collections and existing performance indicators;

REQUESTS the Director-General:

- (1) to ensure the effective engagement of all key stake holders;
- (2) to report to the Sixty-fourth World Health Assembly on progress on the work of the Commission on Information and Accountability for Women's and Children's Health in connection with the agenda item concerning the Millennium Development Goals.

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

1. Resolution Health-related Millennium Development Goals: WHO's role in the follow-up to the high-level plenary meeting of the sixty-fifth session of the United Nations General Assembly on the review of the Millennium Development Goals (September 2010)	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected result:
10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.	10.4 Country health-information systems that provide and use high-quality and timely information for health planning and for monitoring progress towards national and major international goals strengthened.
	10.5 Better knowledge and evidence for health decision-making assured through consolidation and publication of existing evidence, facilitation of knowledge generation in priority areas, and global leadership in health research policy and coordination, including with regard to ethical conduct.
	10.11 Norms, standards and measurement tools developed for tracking resources, estimating the economic consequences of illness, and the costs and effects of interventions, financial catastrophe, impoverishment, and social exclusion, and their use supported and monitored.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The support to the work of the Commission on Information and Accountability for Women's and Children's Health is expected to:	
<ul style="list-style-type: none"> • lead to better knowledge and evidence for health decision-making at country and global levels (expected result 10.5) • contribute to strengthening of country health information systems (expected result 10.4) • improved tracking of resources at country and global levels (expected result 10.11). 	
Using the current indicators, results of implementation can best be measured through the proportion of low- and middle-income countries with adequate monitoring of the health-related Millennium Development Goals that meet agreed standards (indicator 10.4.1). Currently, 40% of countries meet standards; the target is 60% by 2013.	

<p>3. Budgetary implications</p> <p>(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities). US\$ 2.5 million for provision of technical and administrative support to the Commission.</p> <p>(b) Estimated cost for the biennium 2010–2011 (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\$ 2.5 million at headquarters.</p> <p>(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011? No.</p>
<p>4. Financial implications</p> <p>How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?</p> <p>Specified voluntary contributions provided by Member States for the work of the Commission.</p>
<p>5. 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). Headquarters level.</p> <p>(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below. The resolution can be implemented by existing staff.</p> <p>(c) 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). Not applicable.</p> <p>(d) Time frames (indicate broad time frames for implementation of activities). From January 2011 to September 2011.</p>

Dr GOPEE (Mauritius), speaking on behalf of the Member States of the African Region, said that the Millennium Development Goals had been central to efforts to reduce global poverty and inequality and that WHO had been a crucial partner in that effort. As the African Region continued to experience a high burden of disease, it was important for the Region to capitalize on the favourable global policy situation created as a result of the high-level plenary meeting of the sixty-fifth session of the United Nations General Assembly on the review of the Millennium Development Goals. Special attention must be given to countries where progress had been limited owing to conflict, poor governance, economic or humanitarian crises, or lack of resources. The focus should shift to establishing a booster package of investment and support that would create an environment that would enable countries to progress faster. Targeted investment in areas such as access to energy, expanding opportunities for women and girls, and health and education would have significant multiplier effects on growth and prosperity. Partnerships would be needed in order to mobilize the necessary resources. Women's health issues continued to have priority, and should therefore be incorporated into existing programmes. Efforts to ensure the availability of high-quality medicines and medical products should also be stepped up.

Although progress had been made across the Region, trends indicated that some of the targets might not be reached by 2015. The main challenges facing the countries of the Region were to identify the reasons for success or failure through research, to develop country-specific strategies to support the

Member States at greatest risk of not achieving the Goals, to support Member States in the preparation of implementation plans in order to scale up interventions, and to prioritize interventions so as to allow the reallocation of resources where possible. In order to monitor progress more closely, monitoring and evaluation teams might be set up in each country, with the WHO country representatives serving as focal points.

Mr LARSEN (Norway) urged the Secretariat to re-double its efforts to strengthen the WHO country offices in order to ensure better national responses and to set clear targets so that it fulfilled all its responsibilities in respect of the Secretary-General's Global Strategy for Women's and Children's Health. He also urged the Secretariat to ensure that the statistics published in the *World health statistics* were up to date and to facilitate a coherent synthesis of data from various sources in order to avoid discrepancies in the data published. He was pleased that the Director-General had been asked to lead the development of the accountability framework; the governing bodies should follow that work closely. That was the aim of the draft resolution proposed by Norway and several other Member States.

Professor HAQUE (Bangladesh) said that his Government was committed to achieving the Millennium Development Goals and had received special recognition from the United Nations for its progress in reducing infant and child mortality. Nevertheless, several areas required increased attention if the Goals were to be attained by 2015, namely: prevention of childhood illnesses, resource mobilization for initiatives related to the health of women and children, innovative mechanisms to improve health systems, and better accountability and gathering health intelligence from various sources. Further support would be required to resolve health problems caused by climate change and by tuberculosis, malaria and neglected tropical diseases. In addition, investment was needed in order to strengthen health care systems and achieve universal coverage. WHO should develop policy and technical guides for that purpose. He endorsed the recommendations made by the member for Norway.

Dr PÁVA (alternate to Dr Kökény, Hungary) speaking on behalf of the European Union, said that the candidate countries Turkey, Croatia, the former Yugoslav Republic of Macedonia and Iceland; the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia; and the Republic of Moldova, Armenia and Georgia aligned themselves with her statement. In order to achieve the Millennium Development Goals, it was essential to implement the principles referred to in resolution WHA62.12, namely, inclusive leadership, equity, patient-centred care and health in all policies. She drew attention to the outcome document of the high-level plenary meeting of the United Nations General Assembly on the Millennium Development Goals, which contained a section uniting the three health-related Millennium Development Goals under a health systems approach. The European Union's policy on global health was in line with that approach. It was important to continue strengthening health systems and to provide more funding for health-related issues in an integrated health systems approach, in line with the commitments made in the Paris Declaration on Aid Effectiveness, the Accra Agenda for Action and the International Health Partnership and related initiatives. The health-related Goals must not be seen as separate from the other Goals, as health was a critical element for reducing poverty and promoting sustainable growth and stability.

She welcomed the adoption of the United Nations Secretary-General's Global Strategy for Women's and Children's Health and the establishment under the auspices of WHO of the Commission for Information and Accountability for Women's and Children's Health. WHO, as a leader in the achievement of the health-related Millennium Development Goals, should annually review in detail successes and gaps in order to agree on concrete action to facilitate progress, in addition to its normative, monitoring and coordinating work.

She supported the draft resolution.

Mr CHANDRAMOULI (India), drawing attention to the achievements and activities in his country with regard to the health-related Millennium Development Goals, particularly in the areas of

child mortality and vaccinations, said that, although significant progress had been made in providing primary health care, even in the most remote regions of the country, much remained to be done if India were to achieve the health-related Millennium Development Goals by 2015. The Government was engaged in a large-scale effort to strengthen the health system, which had had positive effects on various programmes, including those on malaria and tuberculosis. It was also developing a strategy to tackle undernutrition, and was taking action on some health determinants, such as water, sanitation and housing.

Dr CHISTYAKOVA (adviser to Professor Starodubov, Russian Federation) said that initiatives in her country with regard to the health-related Millennium Development Goals, in particular in relation to maternal and child health, had resulted in a decrease in maternal mortality ratios and child mortality rates. Russian specialists were working with the Secretariat on several international initiatives aimed at strengthening health systems, improving maternal and child health, and enhancing immunization programmes in other countries. She supported the draft resolution.

Mrs HANJAM DA COSTA SOARES (Timor-Leste) said that her country was strongly committed to achieving the Millennium Development Goals, particularly those related to health. Many programmes had been implemented and policies and monitoring mechanisms had been developed in order to improve the health-care system. She had some minor amendments to the draft resolution, which she would submit in writing to the Secretariat.

Dr YUSOF (Brunei Darussalam) said that, despite the global progress made towards achieving the health-related Millennium Development Goals, much work remained to be done. He commended the secretariat for working closely with Member States, other organizations in the United Nations system and other relevant bodies to monitor progress and identify shortcomings in activities related to the Goals. The inclusion of health-related goals in the Millennium Development Goals had provided the impetus for Member States to strengthen national health-care systems. It was imperative that WHO continued to provide guidance and support on the issue, while also working to secure support from partners and playing a leadership role in monitoring and evaluation and in ensuring accountability for health.

Mrs GIDLOW (Samoa) warned that some countries were not likely to achieve the Millennium Development Goals by 2015. Her country was within reach of its indicators for Goals 4, 5 and 6, but still had problems with maintaining immunization coverage for children and improving antenatal care for women. The United Nations Secretary-General's Global Strategy for Women's and Children's Health should help to strengthen existing country-level mechanisms. Her country was also keen to learn from the experience gained through the implementation of resolution WHA63.24 on the prevention and treatment of pneumonia in children. It would further welcome the Secretariat's support in the treatment and management of the drug-resistant tuberculosis that had been introduced into the country by migrant workers.

Samoa had sought to implement the Paris Declaration on Aid Effectiveness at national level through a sector-wide approach; its programme for health, launched in 2008, was based on the health-sector plan for the period 2008–2018 and had facilitated better resourcing of health programmes, better coordination of service provision, a stronger collective commitment to strengthened health systems based on health promotion and primary health care, and more practical monitoring and evaluation. Improvements in health information systems were essential to efforts to achieve the Millennium Development Goals. Efforts to create an integrated programme among the competing priorities in the health field should not distract attention from the Goals.

From its sector-wide approach, her country had learnt that harmonization of donor assistance by means of World Bank conditions and procedures was not as straightforward as it appeared. Health professionals were technical specialists, who were often placed in situations where the conditions governing pooled resourcing were beyond their area of expertise. Although WHO was not a partner in the sector-wide approach programme, the Organization could provide support by articulating a

position on the issue in relation to the achievement of the Millennium Development Goals. She supported the draft resolution.

Dr REN Minghui (China) said that, despite the progress reported, imbalances remained in the achievement of the various Millennium Development Goals and between regions. The United Nations high-level plenary meeting had brought some hope: the outcome document demonstrated commitment and contained bold new initiatives, including the Secretary-General's Global Strategy for Women's and Children's Health, and more than US\$ 40 000 million had been pledged. The Global Fund to Fight AIDS, Tuberculosis and Malaria had recently received pledges of US\$ 11 700 million. Donor countries should fulfil those pledges as quickly as possible. He noted that WHO was working to improve alignment and coherence of health efforts at country level through the International Health Partnership and related initiatives (IHP+). The role assigned to WHO by the United Nations Secretary General, to formulate a framework for accountability and results, was appropriate in view of the Organization's mandate for leadership and coordination.

China provided various kinds of assistance in the health field to other countries, particularly in Africa, and would continue to contribute to the achievement of the Goals. As the deadline of 2015 neared, WHO must consider its further activities after that date. He sought clarification of the size of the shortfall in the funds required to realize the Goals and the measures planned to make up the amount required. He supported the draft resolution.

Ms BILLINGS (Canada) said that her country was providing strong support for the health-related Millennium Development Goals, making significant investments in health systems through the Africa Health Systems Initiative and a range of health programming initiatives, guided by the principles of the Paris Declaration on Aid Effectiveness. It continued to promote donor coordination in the health sector. She commended WHO's active engagement in both the high-level plenary meeting and the Secretary-General's Global Strategy for Women's and Children's Health. Noting that the Prime Minister of Canada was Co-Chairman of the Commission on Information and Accountability for Women's and Children's Health, she pledged that Canada would work closely with WHO and the Commission to develop a sound framework for global reporting, oversight and accountability related to women's and children's health. She supported the draft resolution.

Dr TAKEI (adviser to Dr Omi, Japan) welcomed the Secretary-General's Global Strategy for Women's and Children's Health and requested that the Secretariat inform Member States of the status of the accountability framework for the Strategy before the Sixty-fourth World Health Assembly. In designing the framework, adequate consideration should be given to effective coordination of the various initiatives, accountability, and minimizing the burden of data collection falling on vulnerable Member States. At the high-level plenary meeting in September 2010, his country had proposed a model of care entitled Ensure Mothers and Babies Regular Access to Care. Japan planned to hold a ministerial-level meeting in Tokyo in the first half of 2011 as a follow-up to the high-level plenary meeting in order to maintain the momentum of efforts to achieve the Millennium Development Goals. He supported WHO's work towards achievement of the Millennium Development Goal targets.

Dr RASAE (Yemen), speaking on behalf of the Member States of the Eastern Mediterranean Region, acknowledged the success of the United Nations high-level plenary meeting. Some developing countries, and even middle-income countries, in the Region, however, would have difficulty achieving the health-related Millennium Development Goal targets for various reasons, including budget deficits and poverty. It would be difficult for them to ensure adequate funding for their health systems without more assistance from the United Nations system as a whole, but furthermore they needed broader support for achieving sustainable development.

The Secretariat should step up its current efforts to follow up the decisions of the high-level plenary meeting. Member States should increase collaboration between and among different sectors of society and among development partners in order to ensure that health was at the centre of the efforts to achieve all the Millennium Development Goals. More emphasis should be placed on primary health

care as a way of improving health care overall, but, in order to achieve that aim, more cooperation was needed at the national, regional and international levels and involvement of all stakeholders. A coordinated approach was essential in order to overcome obstacles and achieve health goals. The Secretariat should also increase its support for Member States' data-collection activities and provide tools and resources to enable them to enhance their health interventions, develop their health services, train staff, draft legislation, and improve activities in the field of nutrition and family health. His Government was about to embark on its fourth five-year plan, thereby taking a large step towards the achievement of its health-related Millennium Development Goal targets. It also planned to concentrate on specific health issues such as pneumonia, which was a serious problem in the country.

Dr MOHAMED (Oman), commending the report, noted the reference (paragraph 4) to the high mortality in children under five years of age due to diseases such as pneumonia, but without explanation. Many countries had such high mortality rates because they could not afford vaccines or other interventions. They required more support if they were to achieve the health-related Millennium Development Goals.

The report also referred (paragraph 6) to a reduction in maternal mortality of 34% between 1990 and 2008 and (paragraph 7) to the fact that 62% of women in developing countries were using some form of contraception. Presumably, therefore, there had also been a reduction in the number of women giving birth, which must be partly responsible for the reduction in maternal mortality.

He approved of the call in paragraphs 33 and 34 for greater accountability in health matters. It was to be hoped however, that reporting and feedback to the many international agencies involved would not draw resources away from the activities themselves. He agreed with the member for Yemen that the emphasis on primary health care must be maintained. At the same time, in order to improve maternal and child health, it was important to enhance attention to health in homes.

Dr DAULAIRE (United States of America) said that his Government had recently unveiled a new official development policy, which focused on the Millennium Development Goals. The United States was investing more than US\$ 8000 million a year in the President's Global Health Initiative towards the achievement of the health-related Goals through programmes that emphasized integrated delivery of essential health services to those most in need; the needs and active engagement of women and girls; strengthening of country-owned health systems; rigorous measurement of results for continuous improvement and accountability; and innovative approaches and strong partnerships between governments, civil society and the private sector.

However, despite some signs of progress, the pace of reduction in maternal mortality worldwide remained slow. The United States supported a comprehensive, woman-centred approach, as in the United Nations Secretary General's Global Strategy for Women's and Children's Health. It also supported the Commission on Information and Accountability for Women's and Children's Health. He welcomed WHO's continued focus on the health-related Goals and its renewed leadership in reproductive, maternal, neonatal and child health. He supported the draft resolution.

Mr LAMBAA (Mongolia) shared the concerns expressed by previous speakers about the slow progress towards the achievement of Millennium Development Goals 4 and 5. He supported the Global Strategy for Women's and Children's Health. Mongolia had already achieved Goals 4 and 5: maternal mortality had been reduced by a factor of three over the previous five years, and infant mortality by a factor of two. He supported the draft resolution.

Mr FLORES (Honduras)¹ said that the Millennium Development Goals were a national priority for his country. The support, guidance, coordination and cooperation of the Secretariat were essential if some Member States were to achieve the Goals. New threats were appearing, such as the outbreaks

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

of cholera in Haiti. Despite the progress achieved by his country and others, they would achieve even more with stronger and more effective health systems, better training and targeted international support, both for health and for economic and human development in general.

New types of drug resistance were emerging globally. One of the most useful ways of tackling that problem was the International Drug Purchase Facility (UNITAID), which should be expanded. The combined efforts of international organizations and increased collaboration among partners at all levels were yielding benefits for world health. He encouraged WHO to continue its efforts to consolidate such collaboration and expressed support for the draft resolution.

Ms NORTON (Consumers International), speaking at the invitation of the CHAIRMAN and also on behalf of the International Lactation Consultants Organization, said that many international bodies, including the United Nations Standing Committee on Nutrition, and the United Nations Secretary-General's Global Strategy for Women's and Children's Health had recognized the value of early and exclusive breastfeeding and continued breastfeeding with complementary feeding. A series of articles on neonatal, child and maternal survival published in a leading medical journal had emphasized that interventions related to early, exclusive and continued breast-feeding were cost-effective and had an important impact on poverty reduction and health. She urged the international community to include breastfeeding as an indicator of progress in the achievement of the Millennium Development Goals. Organizations in the United Nations system and donor countries had a responsibility to increase financial and technical support for training of health workers and the support, promotion and protection of breastfeeding.

Ms BARRY (International Council of Nurses), speaking at the invitation of the CHAIRMAN and also on behalf of the International Pharmaceutical Federation, the World Confederation of Physical Therapy, the FDI World Dental Federation and the World Medical Association (together the World Health Professions Alliance), welcomed the progress made towards the achievement of the Millennium Development Goals, particularly the reduction in maternal and child mortality, the reduction in the incidence of HIV co-infection with tuberculosis, and moves towards universal access to antiretroviral therapy. However, the slow rate of progress still gave cause for concern. Investment in known and tested interventions, such as WHO's activities for the prevention and treatment of pneumonia as a measure to reduce child mortality, must increase.

Health professionals could make a considerable contribution to the achievement of Goals 4, 5 and 6, but their achievement could not be completed without progress in other areas, such as food security, gender equality and wider access to education. The current difficulties included health systems weakened by shortages and emigration of health workers, pandemics, conflicts and the world economic crisis. She called upon governments to seek equitable, sound and sustainable funding strategies to strengthen health-care systems and to redress the crisis in human resources for health through appropriate recruitment and retention strategies.

She welcomed the outcome document of the United Nations high-level plenary meeting and the bold new initiatives such as the Secretary-General's Global Strategy for Women's and Children's Health. It was gratifying to see that WHO was already mobilizing partners and resources in order to accelerate progress towards the achievement of the Millennium Development Goals and targets.

Mr JAFRI (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, commended the commitment of all stakeholders to the achievement of the Millennium Development Goals and the many successes so far. In order to improve living standards, tackle poverty and create opportunities for people to realize their aspirations, however, health-care systems and the delivery of care had to be improved. Patients must be involved in both the design and the delivery of their care.

When designing strategies to achieve the health-related Millennium Development Goals, it was also important to recognize the burden of noncommunicable diseases, which constituted a major health-care challenge. Those diseases were being more widely noticed, as evidenced by the plans to hold a high-level meeting of the United Nations General Assembly on the topic in September 2011.

His organization helped to reduce the burden of living with a noncommunicable disease in various ways, including the promotion of health literacy and access to health information, support for those living with chronic conditions, promotion of access to treatment, and awareness-raising activities for the prevention and treatment of noncommunicable diseases. Those interventions were designed to reduce the impact of disease and prevent individuals and families falling into poverty. His organization would continue to support WHO and other interested stakeholders in their efforts to achieve the Millennium Development Goals.

Dr KIENY (Assistant Director-General), replying to a point raised by the member for Oman, said that, while fertility had declined at a global level, the absolute number of births had not declined because the world population had continued to increase. The 34% decline in maternal mortality ratio was therefore real. Replying to a question asked by the member for China, she said that information about the shortfall in the funding required to achieve the Millennium Development Goals was contained in documents EB128/22 and EB128/24.

Responding to a question asked by the member for Norway, she said that the most recent data available appeared in the annual *World health statistics*, issued shortly before the World Health Assembly, which was then used by the United Nations Statistics Division for the preparation of the global report on the implementation of the Millennium Development Goals. However, there were gaps in the available information: for instance, some countries lacked vital statistics systems that could produce mortality figures broken down by age, sex and cause of death. The Commission on Information and Accountability for Women's and Children's Health was expected to identify ways of strengthening health information systems in order to provide timely and robust health information.

Dr BUSTREO (Assistant Director-General) thanked members for their commitment to activities to improve the health of women and children and their support for WHO's leadership in implementing the United Nations Secretary-General's Global Strategy for Women's and Children's Health.

The Board took note of the report.

The CHAIRMAN invited the Board to consider the draft resolution.

Mrs HANJAM DA COSTA SOARES (Timor-Leste) suggested the following amendments, which had been agreed with the sponsors. In preambular paragraph 3, the final phrase should be amended to read "... reducing child and maternal mortality", and it should be followed by two new preambular paragraphs, reading: "PP3 *bis* Acknowledging much more needs to be done in achieving the Millennium Development Goals as progress has been uneven among regions and between and within countries; despite the fact that developing countries have made significant efforts" and PP3 *ter*: "... Recognizing the need for working towards greater transparency and accountability in international development cooperation, in both donor and developing countries, focusing on adequate and predictable financial resources as well as their improved quality and targeting".

In preambular paragraph 5, the words "United Nations" should be inserted before "Secretary-General". In preambular paragraph 6, the final phrase should be amended to read "... vital requirements for improving the accountability and responsiveness by governments and international development partners".

In preambular paragraph 9, the word "health" should be inserted before "equity" and the final phrase amended to read "... rights to health of the population should also be addressed in the implementation of the Millennium Development Goals".

In operative paragraph 1, the final phrase should be amended to read "... key stakeholders in the work of the Commission".

Following a request by Dr DAULAIRE (United States of America), the CHAIRMAN suggested that consideration of the draft resolution should be suspended until the following morning to allow for the distribution of a revised text incorporating the amendments in all working languages.

It was so agreed.

(For adoption of the draft resolution, see the summary record of the fifth meeting.)

Cholera: mechanism for control and prevention: Item 4.10 of the Agenda (Documents EB128/13, EB128/13 Add.1 and EB128/13 Add.2)

The CHAIRMAN invited the Board to consider the report on cholera (EB128/13), the revised draft resolution (EB128/13 Add.1) and the associated financial and administrative implications for the Secretariat (EB128/13 Add.2).

Professor HAQUE (Bangladesh) noted that the number of cholera cases was increasing worldwide and affecting new regions. The recent outbreak in Haiti had claimed around 4000 lives. Epidemics were occurring in countries in the South-East Asia Region, and cases had been reported in various countries in the African and Eastern Mediterranean regions.

Fortunately, there had been new developments in cholera control and prevention. WHO's Strategic Advisory Group of Experts had recently recommended that oral cholera vaccines should be used in areas at risk of endemic cholera and considered for use in areas at risk of cholera outbreaks. Cholera vaccine was also on the priority list of vaccines to be considered for funding by the GAVI Alliance. A large-scale feasibility study on the use of cholera vaccine and behaviour-change interventions to decrease the incidence of cholera was under way in his country, and the results would be shared with Member States in due course.

Bangladesh had sent emergency response teams to all countries that had experienced cholera epidemics or major outbreaks since the 1990s. His country could provide support with clinical care, laboratory diagnosis, training and epidemiological expertise. Bangladesh had the capacity, infrastructure and human and other resources to help to control the high incidence of cholera, thereby saving lives and reducing disease-related morbidity.

The WHO Global Task Force on Cholera Control was still operational but facing severe constraints, stretching its capacity to respond to the recent epidemics beyond reasonable limits. The Task Force must be revitalized with adequate technical and financial support.

He encouraged the Board to support the revised draft resolution.

Dr IBRAHIM (Somalia), speaking on behalf of the Member States of the Eastern Mediterranean Region, noted that cholera had re-emerged or been reintroduced in many of those countries, particularly those experiencing crises and complex emergencies. The lack of safe water and adequate sanitation contributed to the risk of epidemics of diarrhoeal diseases, including cholera. Inadequate surveillance and response systems, the destruction of infrastructure, the collapse of health systems and the disruption of disease control programmes and infection control practices seriously impeded the detection and control of emerging infectious diseases in conflict situations. The problem was compounded by ongoing insecurity and poor coordination among humanitarian agencies.

As the recent experience of the flooding in Pakistan had shown, the use of oral cholera vaccines to prevent and control a cholera outbreak should be promoted only if adequate logistical, operational and financial conditions existed and only if the cost-effectiveness of a mass vaccination campaign, compared with traditional public health interventions, was clear. He called upon all other Member States and partners to join in a concerted effort to improve environmental health conditions – including access to safe water and improved sanitation – for the populations of high-risk areas.

Dr PÁVA (alternate to Dr Kökény, Hungary), speaking on behalf of the Member States of the European Union, said that she would submit proposed amendments to the draft resolution to the Secretariat in writing.

Dr DAULAIRE (United States of America) said that his Government was providing significant support for research to prevent and control cholera. An effective and sustainable control strategy

comprised several components, the most important being access to safe drinking-water and proper sanitation and hygienic facilities. Vaccination, improved surveillance and better diagnostics could mitigate outbreaks. Survival depended on the correct administration of rehydration therapy, which required increased preparedness, awareness about oral rehydration, training and prompt access to treatment. Ancillary interventions such as zinc supplementation, nutritional support, hygiene education and improved access to health care were also important. Innovative research was being encouraged on the environmental and social determinants of cholera; the mechanisms by which outbreaks could be predicted, detected, prevented and controlled; strategies to improve water quality at the point of collection or use; development and trials of cholera vaccines and vaccination strategies; and methods to improve access to and use of oral rehydration and other life-saving therapies.

His Government was working closely with local and international partners on cholera prevention and control efforts in Haiti, in particular supporting the United Nations Cholera Inter-Sector Response Strategy for Haiti. Activities included support for cholera treatment centres and units and oral rehydration points; improvements to water and sanitation services; provision and distribution of medical supplies and services; public information campaigns; and training for medical staff and cholera surveillance and monitoring. His Government had recently announced a cholera-response plan, drawn up in collaboration with the Government of Haiti, which focused on prevention, reduction of the number of cases requiring admission to hospital and reduction of the case-fatality rate. The plan complemented the Haitian Government's own programme and had four elements: provision of chlorine for safe drinking-water, expansion of hygiene education, provision of oral rehydration salts, and increased funding for cholera treatment centres and units. His Government was exploring the possibility of a pilot project in which a defined population group would be vaccinated against cholera.

He commended the Secretariat's efforts to raise global awareness of the need to prevent and control cholera and other waterborne diseases and looked forward to continued partnership in developing a comprehensive approach to tackling cholera.

Dr GEDEON (Seychelles), speaking on behalf of the Member States of the African Region, said that cholera remained a major public health problem in the Region. The links between health and safe water, adequate sanitation and sound hygienic practices were often disregarded in decision-making processes, and the institutional structure of most health systems meant that the focus fell on treatment rather than prevention. The African Region accounted for more than 85% of the global cholera burden. The disease was endemic in many of the countries in the Region, and more than 25 of the 46 countries reported cholera epidemics every year: in 2009, more than 200 000 cases had been reported in 28 countries, with a case-fatality rate of 2.37%. The response to a cholera outbreak continued to be reactive and uncoordinated. Many communities were at high risk because of their poor socioeconomic situation and overcrowding resulting from population displacement associated with conflict or flooding.

The African Region had achieved remarkable success in recent years in building up surveillance, response and diagnostic capacities. There were plans to set up an African public health emergency fund that would provide additional resources for epidemic preparedness and response. Challenges remained, which needed more comprehensive responses by the health sector and partners, as emphasized in the report. He called for more investment into developing an effective vaccine against cholera and making it available.

Mr CHANDRAMOULI (India) observed that, although proven methods of control existed, cholera still killed large numbers of people, particularly children. It was disturbing to note that the incidence of cholera had increased steadily since the year 2000. Underreporting of cases was common because of the fear of repercussions on travel and trade. In India, however, nation-wide cholera status reports were produced weekly. He concurred that cholera control depended on not only prompt medical treatment, but prevention, preparedness, response and surveillance. His country's National Institute of Cholera and Enteric Diseases had recently completed phase III clinical trials of an oral vaccine, which had shown a protection rate of 68%.

He proposed two amendments to the draft resolution. A new subparagraph should be added to operative paragraph 1, reading: “to involve the community and to scale up advocacy measures considering the intersectoral nature of the problem”. A new subparagraph should be added to operative paragraph 2, reading: “to further research in the emergence of hybrid-type and drug-resistant cholera”.

Professor HOUSSIN (France) said that the incidence of cholera was an important global indicator of progress in improving access to safe drinking-water and sanitation. He therefore intended to submit a draft resolution on water, drinking-water, sanitation and health, cosponsored by Hungary, Japan, Switzerland, Yemen and other countries. Consultations with the European Union on the draft were currently under way. He supported the draft resolution proposed by Bangladesh.

The CHAIRMAN said that the draft resolution referred to by the member for France should be submitted directly to the Sixty-fourth World Health Assembly in May 2011.

Ms BILLINGS (Canada) supported an integrated approach that encompassed access to safe drinking-water, basic sanitation and hygiene education as complementary elements in the prevention and reduction of waterborne diseases such as cholera. Oral cholera vaccines should be regarded as additional to, and not as a substitute for, broader and longer-term prevention and control measures. Improved prevention and control of cholera would have a positive effect on other diarrhoeal diseases.

Effective control required not only prompt identification and treatment, with the use of oral cholera vaccine where appropriate, but also a programmatic, multisectoral and coordinated approach that included prevention, preparedness and response. She congratulated WHO and PAHO on their efforts to prevent, respond to and control the cholera epidemic in Haiti and for their efforts to coordinate training in communication for local community health agents and distribute equipment, medicines and supplies to remote and vulnerable communities. Her Government had provided funding for prevention activities in Haiti, including greater access to safe drinking-water and life-saving treatments for children and adults. It was also supporting the continuing work of PAHO in coordinating relief efforts and distributing chlorinated water to affected areas and health facilities.

Dr ST JOHN (Barbados) supported the draft resolution and called on the Secretariat to continue its support for countries affected by and at risk from cholera. Appropriate roles for WHO included technical advice, facilitation of relevant research and support for the development of effective interventions. Since the Region of the Americas was among those at risk for cholera, her Government had updated its cholera action plan, which covered surveillance, training and cooperation with key stakeholders active in sanitation and water quality and control. She asked for more information about the availability of oral cholera vaccines, and urged Member States to support the WHO Global Task Force on Cholera Control.

Dr MELNIKOVA (adviser to Professor Starodubov, Russian Federation) said that her country shared the deep concern of the international community about the deterioration of the cholera situation, especially in developing countries which had limited capacity for treatment and epidemiological surveillance. Sanitary and hygiene measures and the use of cholera vaccines could reduce the duration of cholera outbreaks both in individual countries and at a global level, which would contribute to the achievement of the Millennium Development Goals.

Her Government had allocated funds for training, the strengthening of national laboratory networks, and equipping research establishments working on the prevention, diagnosis and treatment of neglected tropical diseases, including cholera. It was also conducting its own research into a killed cholera vaccine.

She welcomed the efforts of WHO and its partner organizations to provide technical and financial support for vulnerable developing countries. The Russian Federation would continue work jointly with the Secretariat in advising countries on training, the identification and eradication of disease foci and laboratory diagnosis of infectious diseases, including cholera. The Government offered its specialized epidemic-control expertise – independent, highly mobile, quick-response teams

equipped with advanced diagnostic and information technology, up-to-date modular equipment and highly qualified staff. Such teams had operated successfully in several sites affected by serious infectious diseases and had carried out emergency and rescue work after natural and humanitarian disasters and conflicts, where the infrastructure and conventional health-care services had been destroyed. They could be successfully deployed to help other countries as well.

She supported the draft resolution.

Mr YUSOF (Brunei Darussalam) said that the increasing global threat of cholera warranted particular attention because it was likely to delay the achievement of the Millennium Development Goals. He supported the call for the revitalization of the WHO Global Task Force on Cholera Control and for strengthening of WHO's work on cholera through increased collaboration with other relevant stakeholders, especially affected countries themselves, as called for in the draft resolution.

Dr JADUE (Chile) stated that her country had been free of cholera since 1998, thanks to its prevention and control activities, including epidemiological and laboratory surveillance. However, with the outbreak of cholera in Haiti, it had drawn up a set of preventive measures covering general coordination of activities, epidemiological and environmental surveillance, public health measures, disease prevention and control, and strengthening of the response capacity of health services. She supported the draft resolution and emphasized the importance of WHO's support for research into safe, effective and affordable cholera vaccines and the sharing of the relevant manufacturing technology with affected and at-risk countries, in order to increase local vaccine production capacity.

(For continuation of the discussion, see the summary record of the fourth meeting.)

The meeting rose at 12:05.

FOURTH MEETING

Tuesday, 18 January 2011, at 14:40

Chairman: Dr M. KÖKÉNY (Hungary)

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

Cholera: mechanism for control and prevention: Item 4.10 of the Agenda (Documents EB128/13, EB128/13 Add.1 and EB128/13 Add.2) (continued)

Mr EL MAKKOU (Morocco) affirmed the need for programmes and plans relating to cholera to be coordinated and comprehensive and to cover all elements pertaining to outbreaks and protection against cholera, such as safe drinking-water and sanitation. He supported the proposal made by the member for France in that respect. The amendments proposed by the members for Bangladesh and the United States of America to the draft resolution were acceptable on the whole.

He proposed the insertion, in the second preambular paragraph of the draft resolution, after “neglected”, of wording to the effect that, despite the efforts undertaken, certain areas of scientific research into cholera required further attention. He had further proposals for amendments, which he would submit in writing to the Secretariat.

Mrs GIDLOW (Samoa) expressed support for the amendments to the draft resolution proposed by the members for Bangladesh and the United States of America.

Mrs NYAGURA (Zimbabwe)¹ acknowledged the assistance, including that of the Secretariat, to her country in bringing under control a severe outbreak of cholera in 2008–2009 that had resulted in many deaths, and urged all development partners to intensify similar current efforts in Haiti. She supported the call by the member for Bangladesh for a coordinated, multipronged approach at the national, regional and international levels. African countries shouldered 82% of the global burden of cholera, and, although they were scaling up efforts to combat the disease, long-term investment and sustained political commitment from the international community were also required. Socioculturally sensitive issues relating to personal hygiene and risky behaviour must be addressed, and she urged the Organization to support relevant activities. Further, she called on the Organization and all stakeholders to support the African Public Health Emergency Fund, whose creation had been approved by the Regional Committee for Africa,² and appealed for coordination between the WHO Global Task Force on Cholera Control and the Rapid Response Team that had been established by the Regional Office for Africa.

Dr NICKNAM (Islamic Republic of Iran)¹ said that, despite efforts to ensure timely reporting of outbreaks and effective early-warning systems, reporting problems remained, leading to major difficulties and putting neighbouring countries at risk. Fears of unjustified sanctions on travel and trade needed to be addressed, and the provisions of the International Health Regulations (2005) relating to reporting, including under-reporting, should be reviewed.

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

² Resolution AFR/RC60/R5.

Dr CHAWETSAN NAMWAT (Thailand)¹ welcomed the draft resolution with its proposed amendments. He proposed that, in the second preambular paragraph, “an endemic area” should be replaced by “endemic areas”; in the third preambular paragraph, “safe” should be inserted before “potable water”; and in the fourth preambular paragraph, “epidemiological” should be inserted before “information”. Thailand wished to cosponsor the draft resolution.

Professor HAQUE (Bangladesh) thanked speakers for their comments and expressed appreciation for the commitment to developing a sustainable mechanism for controlling and preventing cholera.

Dr FUKUDA (Assistant Director-General) noted the agreement on the growing threat posed by cholera and the need for intensified prevention and control efforts. Cholera, which disproportionately affected poor areas, was a marker of environmental health. It was not appropriate or adequate to consider cholera simply as an epidemic disease; it was endemic in many areas. A comprehensive package of measures was needed, covering, for instance, reporting, preparedness, prevention, treatment, sanitation and hygiene, and, as a complementary component, vaccination. He thanked Board members for their offers of assistance in that respect.

The CHAIRMAN invited the Board to take note of the report and suggested that further consideration of the item should be postponed until a consolidated draft resolution had been prepared and distributed to the Board.

It was so agreed.

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

Health system strengthening: Item 4.5 of the Agenda (Documents EB128/8 and EB128/37)

The CHAIRMAN, noting that four draft resolutions had been circulated and that a fifth was soon to be issued, proposed that discussion of the item should be postponed until all the drafts were available to Board members.

It was so agreed.

(For continuation of the discussion, see the summary record of the fifth meeting.)

Global immunization vision and strategy: Item 4.6 of the Agenda (Document EB128/9)

Dr PÁVA (alternate to Dr Kökény, Hungary), speaking on behalf of the Member States of the European Union, recognizing that considerable progress in vaccination coverage had been made between 2000 and 2009, observed that progress remained slow or non-existent in some countries with high birth cohorts and that the goals of the Global Immunization Vision and Strategy 2006–2015 for national and district-level coverage had not been met. Member States were finding it difficult to achieve and maintain high global vaccination coverage because of prevailing misconceptions among the general public and even health personnel, including for example a supposed link between the combined live vaccine for measles, mumps and rubella and autism. Scientific evidence of the safety of vaccines should help to eliminate such misconceptions and lead to higher coverage in the near future. The introduction of high-priced vaccines was further burdening national immunization programmes,

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

and the issue of financial sustainability would become increasingly important. Research into new vaccines must be reinforced and the availability of second-generation vaccines increased.

In Europe, the largest measles epidemics had occurred in disadvantaged regions or among those populations that had the highest proportion of unvaccinated children. In order to achieve the goal noted by the Health Assembly in May 2010 of a 95% reduction in measles mortality by 2015 compared to 2000,¹ routine immunization with two doses should be promoted, barriers to immunization removed, and supplementary immunization campaigns conducted in high-risk regions. Health systems must be strengthened in low-income countries, which often lacked the infrastructure, skilled staff and monitoring systems necessary to undertake effective vaccination programmes.

Mr CHANDRAMOULI (India) gave an overview of results that had been achieved in his country under the Government's Universal Immunization Programme. Vaccination of all children against hepatitis B had been introduced at the beginning of 2011 and Japanese encephalitis vaccine would be administered in all districts endemic for that disease in 2011. Overall immunization coverage rates were rising. A computerized Health Management Information System had been launched, in which data on immunization were collected at all levels of the health-care system. Particularly encouraging had been a substantial drop in the number of cases of poliomyelitis: only 41 cases had been reported in the first 51 weeks of 2011. Measles vaccination had been extended to cover children up to the age of five years who had not been vaccinated in their first year of life and supplementary immunization activities were in process.

Mr HAGE CARMO (adviser to Dr Buss, Brazil) said that, although the Region of the Americas had, with the support of PAHO, succeeded in eliminating vaccine-preventable diseases, it faced major challenges in maintaining high levels of immunization and epidemiological surveillance, which represented a significant cost to health-care services and were especially burdensome for developing countries. The frequent export of diseases such as measles and rubella from countries that had not yet eliminated them exacerbated those challenges.

Progress towards eradicating poliomyelitis and lower measles mortality rates resulting from higher vaccination rates were contributing to the achievement of Millennium Development Goal 4 (Reduce child mortality). Further measures were needed, and the report should have referred to the meeting of the Global Technical Consultation to assess the Feasibility of Measles Eradication (Washington DC, 28–30 July 2010), which had concluded that measles could and should be eradicated at the global level. Activities to eradicate measles should further be used to enhance control of rubella and prevention of congenital rubella syndrome.

Dr BIRINTANYA (Burundi), speaking on behalf of the Member States of the African Region, drew attention to the remarkable progress achieved by African countries in raising immunization coverage rates for vaccine-preventable diseases to high levels and introducing several new or underused vaccines, notably those against hepatitis B and *Haemophilus influenzae* type b infections and the conjugated pneumococcal and meningococcal A vaccines. Surveillance networks had been strengthened and supplementary vaccination activities undertaken. Nevertheless, concerns remained, such as the persistence of wild poliovirus, multiple outbreaks of measles, and urban transmission of yellow fever in central and west Africa. That situation reflected the lack of funds for vaccination programmes and highlighted the indispensable nature of funding from the international community. The monitoring and regulatory authorities in countries that produced vaccines should be strengthened in order to ensure vaccine quality. Strong political commitment must be maintained at all levels in order to achieve even higher levels of immunization coverage and accelerate the fight against vaccine-preventable diseases.

¹ Document WHA63/2010/REC/3, summary records of the second and fourth meetings of Committee B.

Dr MOHAMED (Oman), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that all the countries in the Region were implementing the Global Immunization Vision and Strategy 2006–2015, which served as a framework for their vaccination activities. Progress had been made in extending immunization coverage with hepatitis B vaccine and the combined measles, mumps and rubella vaccine and in reducing the mortality rate for rubella, but there remained problems in areas such as ensuring immunization coverage against measles and strengthening progress towards Millennium Development Goal 4 (Reduce child mortality) in areas of conflict. He concurred with the member for Brazil that links should be established between the campaigns against measles and rubella. More resources were required to implement routine vaccination programmes. The number of deaths averted each year through immunization underlined the importance of ensuring greater access to vaccines. WHO had made some progress in that respect, but efforts needed to go further as the cost of vaccines was prohibitively high in many cases. Initiatives such as the advance market commitment and access to anticancer, antiretroviral and other medicines should be expanded, and issues related to intellectual property rights must be resolved.

Dr CHISTYAKOVA (adviser to Professor Starodubov, Russian Federation) noted that the significant progress that had been made worldwide in vaccine-preventable disease control and towards achievement of Millennium Development Goal 4 was largely due to the Global Immunization Vision and Strategy 2006–2015. The Russian Federation was maintaining an immunization coverage rate of more than 90% among children as a result of successful vaccination campaigns. The mass immunization of teenagers and adults against hepatitis B and measles had greatly improved the epidemiological situation and in 2010 the authorities had begun certifying some parts of the country as measles-free. Some cases of wild poliovirus had been reported in 2010, and a vaccination campaign launched in November 2010 had reached more than two million children between the age of six months and 15 years. The annual European Immunization Week served the key function of raising awareness of the importance of immunization and combating misinformation. Her Government had approved funding for advance market commitments for vaccine purchases for 2010–2019, and welcomed the recognition of 2011–2020 as the Decade of Vaccines.

Dr REN Minghui (China) welcomed the progress that had been made under the Global Immunization Vision and Strategy 2006–2015 and the Decade of Vaccines (2011–2020) initiative. He commended the analysis in the report. In China, as a result of an expanded immunization programme completed in 2010, during which more than 103 million people had been vaccinated against measles, great strides were being made towards eradicating that disease by 2012. Activities to monitor the quality of vaccines produced were continuing. He urged WHO to be more active in facilitating the transfer of vaccine technology.

Dr NARVÁEZ (Ecuador) said that Ecuador had incorporated new vaccines, including rotavirus and pneumococcal vaccines, into the national immunization schedule, supported by significant financial investment. No case of measles or rubella had been reported in Ecuador for more than 10 years, and the Government remained committed to eliminating those diseases. However, progress in Ecuador and the Region of the Americas was being threatened by imported cases of measles and rubella, as a result of the deferral of immunization programmes in other parts of the world due to factors such as misinformation about the effects of vaccination. Member States should address factors that threatened the progress achieved and establish deadlines for the elimination of measles and rubella worldwide. A detailed joint strategy should be formulated to promote vaccination among all age groups, for which purpose WHO should facilitate the search for mechanisms to enable access to vaccines to be widened and their costs reduced.

Professor HAQUE (Bangladesh) said that immunization was a high priority in Bangladesh, and the national immunization programmes for the previous two years had been launched live by the Prime Minister on television. Bangladesh had received an award from the GAVI Alliance for its success in vaccination programmes, which were administered through vaccination centres and mobile

centres in order to ensure the widest possible coverage. The Government was committed to achieving and sustaining immunization targets. With the recent significant reduction in measles cases and increase in rubella cases, surveillance of congenital rubella syndrome was essential. The GAVI Alliance should consider including the rubella vaccine in its vaccine-support list, and should strengthen and expand its co-financing mechanism beyond 2015 until all countries eligible for its support were in a position to finance vaccine procurement.

The Government was working closely with the United Nations and other development partners towards achieving the Millennium Development Goals by 2015. To that end, there should be a greater focus, at country level, on preventing childhood illnesses, mobilizing resources for women's and children's health, improving health systems and ensuring better accountability and information mechanisms.

Dr DAULAIRE (United States of America) said that the report, although useful, should have highlighted surveillance and assessment as crucial factors in monitoring the impact of vaccination programmes. He acknowledged the Director-General's leadership in global poliomyelitis eradication, and applauded the steps taken towards achieving that goal by the Governments of India and Nigeria. His Government remained strongly committed to poliomyelitis eradication through continued funding, advocacy and technical support, and urged other donor countries to prioritize that goal and recognize the importance of financing and promoting the use of inactivated poliovirus vaccine.

Even though global measles eradication remained a goal, more work was required on controlling measles by reducing mortality, sustaining high coverage of the second dose of measles-containing vaccine and strengthening surveillance, in order to meet the goals that had already been set for 2015. Progress in the South-East Asia Region and barriers to efforts to combat measles worldwide should be regularly reviewed as part of the discussion on setting an eradication timeline. While the global poliomyelitis eradication programme struggled to complete its monumental task, it would be premature and counterproductive to launch yet another official eradication campaign.

His Government strongly supported WHO's leadership in ensuring that the priorities of the Decade of Vaccines (2011–2020) extended beyond the development of new vaccines to include strengthening delivery of immunization services, improving data quality and conducting surveillance. He urged the Secretariat to incorporate developing country input more thoroughly in that area in order to strengthen country ownership of delivery strategies. Even though the Organization was experiencing budget constraints, it was important to prioritize assessed contribution funds for immunization programmes.

Dr TAKEI (adviser to Dr Omi, Japan) said that Japan had recently been focusing on countermeasures to deal with vaccine-preventable diseases and had made significant progress in immunizing children against measles, leading to a drastic decrease in its incidence. The Government actively supported the vaccination work of WHO, UNICEF and other partners through the Expanded Programme on Immunization and by donating vaccines through bilateral aid and transferring technology to countries that were capable of producing vaccines domestically.

Dr JADUE (Chile) said that the necessary political and financial commitment existed in Chile to achieve and maintain a national immunization coverage rate of 90%. Since 2009 the Government had been reformulating the national immunization programme to reflect the epidemiological situation by incorporating more vaccines, including the conjugated pneumococcal vaccine for all infants, with resulting improvements in the quality and logistics of vaccination programmes and in reporting through the use of online systems. Broad public health programmes were needed that included education of families and society as a whole and countering misinformation, especially among health workers.

Mr YUSOF (Brunei Darussalam), noting the progress made in immunization coverage, pointed out that the 2010 target set in the Global Immunization Vision and Strategy 2006–2015 was yet to be reached in some countries and supported the strategies proposed for overcoming obstacles. His

country recognized the importance of inducing high levels of immunity at an early age and of surveillance in controlling and eliminating vaccine-preventable diseases. Surveillance of acute flaccid paralysis was being maintained in anticipation of global poliomyelitis eradication, and guidelines on preparedness and response to the import of wild poliovirus and a contingency plan for a poliomyelitis outbreak had been developed. His Government was fully committed to achieving the twin goals set for the Western Pacific Region of eliminating measles and hepatitis B by 2012. He welcomed the Decade of Vaccines (2011–2020) initiative, and looked forward to the formulation of a global action plan for strengthening national vaccination strategies.

Dr ST JOHN (Barbados) commended the leadership of the Caribbean Community in efforts to eradicate poliomyelitis. Through activities by the Caribbean Epidemiology Centre with respect to standardization, surveillance and quality control, her region sought to ensure at least 90% national immunization coverage rates. The Secretariat must support countries with large numbers of cases of measles and rubella. The annual Vaccination Week in the Americas was a useful event for raising awareness. PAHO was to be commended for providing training on the application of health economics to the process of choosing which vaccines to include in the national immunization programme. The PAHO Revolving Fund for Vaccine Procurement had facilitated the purchase of vaccines at affordable rates. She welcomed the continuing work by WHO to engage suppliers through advance commitments to ensure vaccine production, and commended the support of the Organization and stakeholders such as the Bill & Melinda Gates Foundation for research into new vaccines. Health system strengthening would boost countries' capacities to conduct effective disease surveillance and response programmes.

Ms DABRE (Burkina Faso)¹ thanked the Director-General for having accepted her country's invitation to attend a ceremony that had been held on 6 December 2010 in Ouagadougou to launch the new meningitis vaccine. It was vital to break the epidemic cycle in Africa's meningitis belt as soon as possible. Achievement of that goal would require support from WHO and cooperation and assistance from the international community.

Ms CHILDS (MSF International), speaking at the invitation of the CHAIRMAN, supported the rebalancing of the global vaccine strategy so that the introduction of newer vaccines did not prejudice routine immunization. Although new vaccines might avert millions of deaths, the fact that her organization's teams had had to intervene in response to several measles outbreaks demonstrated the weak coverage of immunization with traditional vaccines. Opportunities were missed every day when young children accessing health care were not offered catch-up vaccinations, and financial incentives that rewarded countries for vaccinating children under the age of one year should be extended to cover older children. Funding for routine measles vaccinations and catch-up campaigns should be restored, and encouragement of implementing countries to increase their contribution to vaccination purchase and programmes must continue. Technologies should be developed that were better adapted to the realities of developing countries, as exemplified by the process leading to the low-cost type A meningococcal vaccine. Particularly important would be the development of a more practical one-dose cholera vaccine.

Vaccine prices remained too high. Too little emphasis was given to investing in emerging-country manufacturers that could produce high-quality vaccines at much reduced prices. The report lacked any mention of strategies and specific actions to reduce vaccine prices, which must include measures to stimulate competition and to increase transparency of pricing, technology transfer, support for emerging vaccine-producing countries and removal of intellectual-property barriers. The development of the vaccine against meningitis A, in which developing-country producers and scientists had been active, demonstrated the efficiency of a model that delinked the cost of research from the price of a product and a model of collaboration in order to produce an affordable product.

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

Dr BUSTREO (Assistant Director-General) thanked the Board for its support. Summarizing the debate, she recognized the importance of strengthening health systems in order to encourage routine immunization and the links between poliomyelitis eradication efforts and broader immunization goals such as routine immunization and accelerated elimination of measles. The Strategic Advisory Group of Experts on immunization had reported that measles could and should be eradicated and that the goal for measles eradication should be established on the basis of sufficient measurable progress towards meeting existing goals. She congratulated China on having successfully undertaken the largest-ever measles immunization campaign. Transferring knowledge and strengthening the capacity to produce vaccines were vital, and WHO was committed to working closely with the GAVI Alliance and other partners to lower the cost of vaccines.

The Board noted the report.

Draft WHO HIV/AIDS strategy 2011–2015: Item 4.7 of the Agenda (Document EB128/10)

The CHAIRMAN invited the Board to consider the report and the draft strategy annexed therein.

Dr LUKWAGO (Uganda), speaking on behalf of the Member States of the African Region, recalled that 68% of people living with HIV/AIDS were in sub-Saharan Africa. However, there was a lack of coordination between stakeholders in Africa, where the primary focus was on care and treatment rather than prevention. Consequently, numbers of new HIV infections were surging in Africa. Although the draft strategy was expected to build on earlier progress towards achieving universal access to HIV prevention, care and treatment, the current downward trend in financing threatened to erode the gains to date. He acknowledged the consultation process, even if the period had been relatively short. The draft strategy did not contain clear targets, and the section on monitoring and evaluation should be refined. The action needed to ensure the quality of blood products was not clearly explained. Given the global consensus on the importance of preventing new infections and promoting universal access to prevention, care and treatment, it would be difficult to implement the proposed strategy without placing due emphasis on preventive measures. The draft strategy should be revised with more attention to prevention before being submitted for consideration to the Sixty-fourth World Health Assembly.

Member States had a duty to support the Secretariat in its vital role in coordinating the worldwide response to HIV/AIDS. In turn, the Secretariat should work with countries to harmonize their HIV/AIDS strategies, reduce duplication, minimize wastage and balance investment in prevention, care and treatment. He thanked the international community for its solidarity and support, in spite of the global economic crisis, but appealed for a renewal of that spirit of solidarity and partnership in order to reinvigorate efforts to control HIV in Africa.

Mr PASSERELLI (adviser to Dr Buss, Brazil) welcomed the fact that the proposed strategy had been drafted in line with existing initiatives, particularly the UNAIDS strategy for the same period, and that it was linked to Member States' efforts to achieve the Millennium Development Goals. He acknowledged the Secretariat's consultative process. Brazil, with the support of PAHO, had consulted countries of the Southern Common Market (MERCASUR) on the first draft; he commended the Secretariat's incorporation of most of the recommendations made by the various health ministries. The Brazilian health ministry had contributed US\$ 500 000 to the Secretariat to support efforts to draft and implement the global strategy.

The current draft document was comprehensive, but it could be clearer, more concise and more user-friendly. The introduction should be recapitulated in an executive summary and the text of the strategy itself extracted from chapters III–V. The section on implementation would be clearer and more coherent if a work plan were appended, which contained further information on monitoring and evaluation. He suggested that the Secretariat, in consultation with members of the Board, should review the draft document before it was submitted to the Sixty-fourth World Health Assembly.

Mr PRASAD (adviser to Mr Chandramouli, India) commended the draft strategy and the broad consultative process. The third phase of his Government's national AIDS control programme had been launched in July 2007, and aimed to halt and reverse the epidemic in the country over a five-year period through programmes for prevention, care, support and treatment. The latest statistics indicated that the number of newly detected cases of HIV infection had decreased by more than 50% over the previous decade. The Government was in the process of preparing for the fourth phase of the programme, for the period 2012–2017, and would take account of the draft strategy in that exercise. He endorsed the draft strategy and recommended it to the Sixty-fourth World Health Assembly.

Dr REN Minghui (China), welcoming the draft strategy, said that his Government was in the process of formulating an action plan for the prevention of HIV for the period 2011–2015. WHO's leadership was not limited to advocacy and technical support but should also extend to proposing policies in areas such as a coordinated approach to the reduction in price of antiretroviral medicines drugs, resource redistribution, research, and promotion of effective prevention measures. The Secretariat should consider different countries' situations and provide relevant guidance to countries with high, medium and low HIV prevalence. The targets established in the draft strategy to reduce new HIV infections in children by 90% and HIV-related deaths by 25% would be difficult for some countries to achieve, particularly those with high prevalence of HIV infection, and should be reconsidered. Proper account should also be taken of the human and financial resources needed to reach those targets, and the requirements for training and funding should be estimated.

Dr DAULAIRE (United States of America) approved the emphasis in the draft strategy on WHO's role in supporting national responses to HIV/AIDS, its reaffirmation of internationally agreed HIV commitments, and alignment with the UNAIDS strategy 2011–2015. It should, however, be revised before submission to the Sixty-fourth World Health Assembly. He endorsed its global goals of reducing new HIV infections, eliminating HIV infection in children, and reducing mortality due to HIV/tuberculosis coinfection, as well as the strategic directions. Consideration had to be given, however, to the resources needed to achieve those goals. Opportunities should be identified for improving the cost-effectiveness and efficiency of evidence-based HIV programmes; at a minimum, national governments should commit themselves to shifting resources to measures that were evidence-based, tailored to local conditions and capable of maximizing the impact on health. The level of investment needed to achieve each global goal should be assessed in cooperation with UNAIDS. Furthermore, investment was needed in strategic information, so as to improve the measurement of HIV incidence in adults (especially young adults), paediatric HIV prevalence and incidence, and cause-specific mortality, and in the development and implementation of tools to cost national health sector plans. The Secretariat should work with development partners to improve efficiencies in the implementation and management of development assistance funds and the provision of technical support.

Given the current severe resource constraints, he asked for information on different budget scenarios and their potential impact on WHO's ability to deliver results. The draft strategy should clearly distinguish between those aspects that fell within WHO's area of expertise and those in respect of which its partners were more likely to achieve results. For example, WHO could most effectively establish norms and guidelines for service delivery or provide technical support in relation to vulnerable groups but should recognize that UNAIDS and other agencies had the mandate and expertise for human rights advocacy. The draft strategy should also have placed more emphasis on two of WHO's strengths: building and maintaining a workforce of qualified public health professionals, and strengthening laboratory systems and services.

Despite several references to the need to foster an open competitive market for antiretroviral therapies in order to contain costs, the draft strategy did not explicitly recognize the importance of voluntary licences and the Medicines Patent Pool. Although the draft strategy advocated the use of differential pricing to ensure affordable access to patent-protected medicines, differential pricing did not always have the same impact on pricing as did robust generic competition. The Medicines Patent Pool aimed to enhance competition so as to bring down prices in developing countries. The granting of

a licence by the United States National Institutes of Health to the Pool in September 2010 was an important first step in boosting access, but more companies should join the Pool.

Dr PÁVA (alternate to Dr Kökény, Hungary), speaking on behalf of the European Union, recommended endorsement of the draft strategy, but in a shortened and less complex form. It should include an operational plan providing a clear framework for accountability. The draft strategy's four strategic directions were in line with the European Union's own approach. Strategic direction 1 should place greater emphasis on prevention, which should include behavioural change, the link to sexual and reproductive health, and providing young people with knowledge and support. Particular attention should be paid in that regard to sub-Saharan Africa, but also to the countries of eastern Europe and central Asia, as both showed an alarming increase in the rate of new infections. She welcomed the approach in strategic direction 2 and the emphasis in strategic direction 3 on building strong and sustainable health systems. Particular attention should be paid to the health workforce and sustainable financing of health systems so as to pave the way to universal access. In strategic direction 4 special emphasis should be put on access by young people and key populations to information and commodities meeting their specific needs. She welcomed the recognition in the draft strategy of the role of civil society in the delivery and decentralization of services, the emphasis on health equity, and the need for provision of support to countries for remedying stigmatization, discrimination and human rights abuses.

WHO should reinforce its leadership role and work with UNAIDS and other partners to prepare for the High-level Meeting of the United Nations General Assembly on AIDS (New York, 8–10 June 2011), and continue to play an important role in defining an evidence-based health sector package for HIV prevention and in supporting its national implementation. She was pleased to note the explicit reference in the draft strategy to female condoms; WHO should prequalify new types of female condoms soon so as to improve their availability and affordability. WHO should adopt a comprehensive approach to the integration of HIV prevention in sexual and reproductive and mother-and-child health programmes, develop guidelines and evidence on treatment adherence, and conduct more in-depth studies of the impact of food and nutrition support on HIV programmes.

The draft strategy should be integrated into the Proposed programme budget. She urged WHO to ensure that its strategy supported and formed part of the operationalization of the UNAIDS strategy, whose vision and strategic directions could have been used. WHO should state clearly that it was a cosponsor of UNAIDS, not just a collaborative partner. For successful implementation of the draft strategy in the European Region WHO needed to collaborate with European Union service organizations such as the European Centre for Disease Prevention and Control and the European Monitoring Centre for Drugs and Drug Addiction.

Dr CHISTYAKOVA (adviser to Professor Starodubov, Russian Federation) noted that the draft strategy set clear strategic goals for the coming five years. Her Government had adopted interventions that were in line with the recommendations of WHO and other international bodies and implemented a range of measures that were reflected in the draft strategy, such as access to antiretroviral therapy, treatment for patients co-infected with HIV and tuberculosis or viral hepatitis, testing of blood donations for HIV, and the full range of preventive measures for pregnant women.

Overall, she endorsed the draft strategy, but observed that not all its recommended measures were acceptable to all countries, concurring with the member for China that allowance had to be made for each country's specific situation. For example, strategic direction 1 contained a section on the provision of harm-reduction services for injecting drug users which recommended a comprehensive and high-quality package of services, including needle and syringe programmes and opioid substitution therapy. In 2004, the Russian Federation had introduced a needle-exchange programme in some areas, but later found infection rates were higher than in areas without a harm-reduction programme and where the focus had been on reducing demand and encouraging healthy lifestyles. Current programmes therefore focused on encouraging responsible attitudes to health and strengthening the institution of the family. Moreover, methadone was a prohibited substance in the Russian Federation.

The draft strategy should be global in scope and define comprehensive strategic objectives that could be realized at country level and did not run counter to national legislation. As the member for Brazil had suggested, the document required revision, and the Russian Federation would be willing to participate in that endeavour.

Dr TAKEI (adviser to Dr Omi, Japan) supported the draft strategy, which had been prepared after extensive consultations and had thus ensured consistency with existing strategies. He requested clarification on two points relating to monitoring of its implementation. First, in view of the assessment of the achievement of WHO's strategic objectives that was due to take place in 2013 and the deadline of 2015 for achievement of the Millennium Development Goals, what was the monitoring plan and time schedule? Secondly, how would the 15 different national indicators be used in the monitoring process, given the importance of tailoring those indicators to the country context?

Dr ST JOHN (Barbados) welcomed the inclusivity of the draft strategy, which reflected the consultations with countries. Barbados had been invited to facilitate a national consultation with key stakeholders, the outcome of which had been submitted to PAHO. Overall, her country's National Strategic Plan for HIV Prevention and Control 2008–2013 shared the goals and strategic directions of the draft strategy. That alignment would be relevant to the preparation of the national strategic plan for 2014–2019. Some of the focus areas were reflected in existing initiatives to which the national HIV/AIDS programme was committed, such as expanding HIV testing and counselling, including provider-initiated counselling and rapid testing, targeted prevention, emphasis on most-at-risk populations, and promotion of positive prevention for people living with HIV. Additional initiatives included elimination of mother-to-child transmission of HIV, and strengthening information systems and surveillance.

The draft strategy's goals, indicators and targets should be made clearer, so that the strategic directions for countries could be better linked to the variables. It should also be more inclusive of the private sector, specifically the private health sector, especially in the light of efforts to reduce stigmatization and discrimination in access to services. It should also seek to enhance private–public cooperation.

Dr ALI (alternate to Professor Haque, Bangladesh) strongly supported more targeted funding to strengthen health system performance based on primary health care and, where appropriate, much stronger links between HIV and other health programmes and services, notably those relating to sexual and reproductive health, maternal, newborn and child health, tuberculosis, drug dependence and harm reduction, and hepatitis.

A unique feature of Bangladesh's HIV/AIDS programme was the extensive participation of the non-State sector, especially nongovernmental organizations. Consultations on the draft strategy had involved those stakeholders, and the results had been submitted to the Regional Office for South-East Asia. Although the overall HIV prevalence was low in Bangladesh, the infection rate among injecting drug users was high and more proactive efforts were needed to reduce prevalence in that group. Risky behaviour as well as high prevalence of HIV in neighbouring countries threatened to spread infection in Bangladesh, which therefore needed international technical and financial support to build a strong and sustainable public health system in which public–private partnerships could act as a catalyst.

Mr BABLOYAN (Armenia) endorsed the idea of the draft strategy. More should be done to eliminate stigmatization and discrimination against people living with HIV and to seek and introduce new methods of treatment. The goal of a world free of HIV/AIDS was on a par with that of a world free of poliomyelitis and required the same approach. The early 1990s had seen many poor decisions reflecting an aggressive approach not only to the virus, but also to people living with HIV, sadly, the latter being a situation that still pertained in many countries. Considerable changes had been made in his country's legislation in the past two years, enabling better approaches to prevention, enhancing the rights of people living with HIV/AIDS, and reducing stigmatization and discrimination. For example, it had lifted restrictions on entry and residence for people living with HIV. HIV was not spreading

rapidly in Armenia, but nevertheless intensive efforts must continue in order to contain it, prevent mother-to-child transmission of HIV, and to lower the mortality rate. Further work was required on the draft strategy.

Mr YUSOF (Brunei Darussalam) expressed support for the draft strategy. He acknowledged the inclusive and broad consultative process and the linking of the draft strategy to the achievement of the Millennium Development Goals and its alignment with other global health strategies and plans, in particular the UNAIDS strategy 2011–2015. Its clear goals and strategic directions would help his country to monitor and assess the status and achievements of its own HIV/AIDS programme and to ensure access and equitable treatment. It should, where necessary, be adapted to the local context in order to be acceptable to society.

Ms BILLINGS (Canada) welcomed the fact that the draft strategy was aligned with the UNAIDS strategy 2011–2015, and congratulated WHO on the extensive consultation process. She supported the goals and strategic objectives outlined in the draft strategy and its focus on human rights, gender equality, evidence-based interventions and determinants of health as integral components of the HIV/AIDS response. The draft strategy would serve as a guide for the implementation of national responses in accordance with the specific situation of each country and with WHO's support. The Secretariat's capacity and resources to implement the draft strategy should be further analysed.

Mr EL MAKKOU (Morocco), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed support for the draft strategy and noted its alignment with the UNAIDS strategy 2011–2015. At its fifty-seventh session in October 2010, the Regional Committee for the Eastern Mediterranean had endorsed the regional strategy for health sector response to HIV 2011–2015,¹ which had played a key part in building and strengthening the global strategy by allowing the Region's countries to provide input on the basis of their knowledge and experience. It was particularly important to support countries in their efforts to revise their HIV strategies and to set priorities that took account of the regional and local epidemiological contexts. Civil society also had an important part to play in promoting stronger public health initiatives and in crafting appropriate health-care plans. An appropriate HIV/AIDS surveillance system was needed, focusing on young people and adolescents, and those groups had to be warned against high-risk sexual behaviour. Capacity building was another important aspect of the fight against HIV/AIDS. National plans had to be affordable.

Dr JADUE (Chile) expressed support for the draft strategy, which took account of the lessons learnt by Chile in developing its HIV/AIDS policy over a period of 30 years. Chile would implement the draft strategy in the light of the needs and characteristics of the epidemic in the country, and work for greater integration of efforts at the national, regional and global levels.

Mr LARSEN (Norway) expressed appreciation for the broad-based and inclusive consultations that had led to the draft strategy, which he endorsed. He welcomed its four strategic directions, the emphasis on health system strengthening, and the focus on efficiency and effectiveness. For low-income countries in particular, the shift towards both achieving results and helping to build the capacity of national health systems was especially important. He agreed, however, that the draft strategy should be shortened before the Sixty-fourth World Health Assembly, with a sharper focus on the four strategic directions in relation to the UNAIDS strategy 2011–2015 and WHO's main contributions.

¹ Resolution EM/RC57/R.5.

The division of labour between WHO, other organizations in the United Nations system and partners had been defined in the UNAIDS strategy for 2011–2015. Norway would closely follow WHO's performance within that strategy, and he looked forward to receiving progress reports.

Prevention, including behavioural change, remained the priority, with work on issues relating to gender and stigmatization. Actions needed to be constructive and adapted to local epidemiological contexts. The health sector had a special responsibility for access to services by those most at risk, and as a resource for and advocate of sound public health policies. The Secretariat should expand its performance and provide guidance to Member States, building on evidence and good practice.

WHO and UNAIDS should take advantage of the United Nations high-level meeting on AIDS to be held in New York in June 2011 to raise important issues relating to the draft strategy, such as the need to develop robust health services with a properly functioning workforce, reduction of stigmatization, and ways to foster stronger linkages with work towards achieving Millennium Development Goals 4, 5 and 6, focusing on women, young people and children. The United Nations Secretary-General's Global Strategy for Women's and Children's Health provided a strong platform for such an integrated and results-oriented approach.

Mr PRAZ (Switzerland)¹ welcomed the draft strategy; it built on lessons learnt and was aligned with other international strategies, in particular the UNAIDS strategy for 2011–2015. It also reflected WHO's normative role. Like Norway, Switzerland would closely monitor the division of labour between WHO and other United Nations bodies.

Access to prevention and treatment services was of prime importance. The Secretariat had to ensure, in its policy-making role, that Member States' policies took due account of, and did not discriminate against, most-at-risk and vulnerable populations. The draft strategy should ensure greater involvement of people living with HIV/AIDS at all stages in all national policies. It should also emphasize the close link between HIV/AIDS and sexual and reproductive health.

He enquired about WHO's position in relation to UNAIDS' "Three Ones" system. He also asked what were the baselines for the activities proposed under the four strategic directions and how the results would be measured.

Dr MUKUKA (Zambia)¹ remarked that the draft strategy would be a source of guidance to Zambia in its search for national health-sector responses to HIV/AIDS. It should nevertheless be made simpler, clearer and more results-oriented. It should place greater emphasis on prevention in terms of the generalized epidemic, which accounted for the bulk of new infections each year. Significant progress had been made in terms of treatment, but in Zambia the treatment of children continued to lag behind, in particular with regard to the availability of appropriate and adequate medicines. That aspect should be highlighted in the draft strategy and in WHO country support. The indicators that were to guide responses at country level, as identified in the section on monitoring and evaluation, should be refined.

Dr NICKNAM (Islamic Republic of Iran)¹ highlighted the importance of focusing on the quality of services for HIV-infected people (positive prevention) and vulnerable groups (primary prevention). Both those approaches had been incorporated in the Iranian national strategic plan and were taken up in the draft strategy. Best practices should also be observed. Any plan regarding HIV/AIDS should pay special attention to young people, especially those likely to engage in risky behaviour, and that behaviour constantly changed: drug users, for example, were moving from traditional substances to stimulatory drugs such as amphetamine compounds. The draft strategy and the strategies of other agencies and programmes should be implemented with due consideration for cultural, moral and religious values and sensitivities. Although it was right to reduce the stigmatization of people living with HIV/AIDS, that principle should not apply to persons engaging in risky behaviour.

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

Dr HWENDA (Zimbabwe)¹ said that the draft strategy would provide guidance for national health-sector responses to HIV. She welcomed its four strategic directions and WHO's key contributions. It should nevertheless focus more strongly on prevention, in particular funding for prevention programmes. Greater emphasis should be placed on nutrition, which was mentioned only under noncommunicable diseases. The importance of integrating HIV programmes with those for sexual and reproductive health could not be overemphasized, particularly in a region where the major driver of infection was heterosexual sex. Labour had to be clearly divided between WHO and the other cosponsors of UNAIDS, to avoid overlaps, especially in terms of advocacy and human rights. The most-at-risk populations should be more clearly defined, so as to enable countries to identify them within the context of their epidemics. WHO should help to rally support from partners for national HIV responses. The performance assessment of the Programme budget 2008–2009² had shown that 52% of the approved budget had been made available, and three of six key Organization-wide expected results had been partially achieved; one of those was the production of guidelines to support countries in key policy areas. Notwithstanding the considerable financial constraints faced by WHO, he urged the Director-General to continue to prioritize those areas. In future, the countries affected should be more effectively consulted and represented on technical and strategic advisory committees on HIV/AIDS control.

Dr SANGA (United Republic of Tanzania)¹ agreed with previous speakers that the draft strategy should be revised so as to incorporate preventive strategies benefiting the general population. Concerning the statement in section V that WHO would take bold and innovative actions that challenged conventional HIV and public health responses, she said that rather than “challenge”, the Secretariat should continue to provide guidance to Member States on how best to address the generalized epidemic.

Dr CHEEWANAN LERTPIRIYASUWAT (Thailand)¹ welcomed the draft strategy and expressed appreciation for the broad consultative process that had enhanced the engagement of all stakeholders, including Thailand. Referring to the section on monitoring and evaluating progress and reporting, in section VI, she said that comparing progress towards targets by benchmarking with other countries was politically sensitive, as differences in socioeconomic situations and health systems dictated differences in HIV/AIDS programme outcomes. Efforts should be made to compare trends within rather than between countries, and the results should be used by Member States, international development partners and the Secretariat to recommend effective action for accelerating progress towards the targets. Furthermore, when estimating HIV incidence, the Secretariat should not only apply modelling methods but also focus on developing laboratory capacity and investment in reagents and resources. In countries with civil registration systems, HIV/AIDS-related deaths were always under-reported because of stigmatization, making it difficult to measure reductions in mortality. The challenge was even greater in countries with no civil registration system, in which it was not possible to measure any such progress. Action should be taken urgently to resolve those problems.

Dr LHOTSKA (Consumers International), speaking at the invitation of the CHAIRMAN, proposed several ways to strengthen the draft strategy. Greater attention should be paid to the role of nutrition for persons infected with HIV and of infant feeding as a child survival strategy. Infants' needs and rights should be highlighted rather than subsumed under the generic term “mother-to-child transmission”; indeed, infant feeding and HIV should be integrated into maternal and child health programmes, with promotion of breastfeeding in general populations. Reference should be made to protection, counselling for best practice and the coherent communication strategies needed to change the views of policy-makers, health professionals and parents. Emphasis should be placed on the need

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

² Document EB128/22.

for industry to meet its obligations, including compliance with the International Code of Marketing of Breast-Milk Substitutes and manufacturing according to the Codex Alimentarius. Specifically, the Secretariat had to consider how it could help Member States to ensure that the baby food industry did not use efforts to reduce transmission of HIV to infants as a market opportunity, and how to prevent a move towards artificial feeding leading to increased infant mortality and morbidity.

Ms CHILDS (MSF International), speaking at the invitation of the CHAIRMAN, made some suggestions for improving the draft strategy. Additional numerical targets should be set, for instance for countries to implement main recommendations. Given that national abilities to maintain the pace of expanding improved treatment and prevention services would be sharply curtailed by the donors' recent failure to support the minimum level of funding required by the Global Fund to Fight AIDS, Tuberculosis and Malaria to maintain programmes, Member States should support innovative financing, such as financial transaction taxes or proposals from the Leading Group on Innovative Financing for Development. The Secretariat should monitor, at country level, the operational impact of limited funding. It should assess the risks to national antiretroviral programmes and report back to the Health Assembly. If support for universal access were not maintained, countries would be guilty of snatching defeat from the jaws of victory. Increased patent protection in developing countries had led to higher prices of medicines. Generic competition had been crucial in reducing those prices, and the draft strategy should also refer to mechanisms other than the full use of flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property so as to foster competition and reduce prices; the Medicines Patent Pool was one such example. The Secretariat was right to identify clauses in free-trade agreements that threatened access to medicines, such as data exclusivity.

Ms BARRY (International Council of Nurses), speaking at the invitation of the CHAIRMAN, applauded the consultative process for the draft strategy and welcomed its strategic focus on the goals of universal access to treatment, prevention, care and support, and health-system strengthening. The goals would not be met, however, if health-care providers were themselves falling ill and dying of HIV and AIDS. The support and treatment of health-care workers were vital aspects of strengthening health systems and retaining health professionals; she supported WHO's Treat, Train and Retrain initiative for health professionals, to which the draft strategy did not refer. Her organization had launched Wellness Centres in several African countries to provide HIV-positive health workers and their families with antiretroviral therapies and a range of services including prevention, peer support and stress management. Those Centres had been widely accepted by governments, foundations, pharmaceutical companies, national nurses associations and others. That successful approach should be supported and accelerated. She therefore called on WHO, governments and others to provide health workers with a comprehensive package of services as an important means of strengthening health systems.

Dr NAKATANI (Assistant Director-General) expressed appreciation for the valuable suggestions and recommendations that had been made. Several speakers had described the draft strategy as complex and in need of greater clarity. The Secretariat would therefore organize consultations with members before the Board's final meeting to discuss what changes were required before the draft strategy was submitted to the Sixty-fourth World Health Assembly. Several speakers had referred to the need for interaction with UNAIDS and other global initiatives. Such interaction was important to WHO, which had organized a retreat with UNAIDS before starting work on the draft strategy and had subsequently focused its draft strategy on the role of the health sector. Another important point was the division of labour between agencies, and that explained to some extent why the draft strategy did not place greater emphasis on nutrition, which fell within the purview of WFP.

Regarding the content of the draft strategy, the consultative process had revealed a preference for using internationally agreed targets already in existence rather than inventing new targets, the aim being not to add to the burden on countries. With regard to prevention, he noted that strategic direction 1 did include a focus on the general population. Because in some countries infection rates were rising most rapidly in the most-at-risk groups, the draft strategy had to deal with prevention in

those groups as well as in the general population. It could provide no “one-size-fits-all” solution, as the situation in each country was different, and it therefore aimed to provide a framework for Member States to apply.

Concern had also been expressed about the accessibility of medicines and diagnostics. The draft strategy dealt with that aspect in strategic direction 3, but did not duplicate work being done by WHO in other forums.

With regard to monitoring and evaluation, there were three frameworks: the annual WHO/UNAIDS/UNICEF report: *Towards universal access: scaling up priority HIV/AIDS intervention in the health sector*, together with the UNAIDS epidemiological updates; the WHO programme budget process, which would monitor WHO implementation; and the monitoring of all UNAIDS cosponsors conducted within the UNAIDS monitoring framework, and the unified budget and accountability framework in particular.

Lastly, the draft strategy would be operationalized in three ways: at country level, WHO would continue its work to help to integrate elements of the draft strategy into national strategies and plans; at the three levels of the Secretariat, it would define WHO’s programmes for the coming five years; and it would also promote the coherence of plans among the draft strategy’s key partners.

The DIRECTOR-GENERAL observed that HIV/AIDS was the most multifaceted of issues. There was reason to celebrate the progress that had been made: fears that medicines would not be taken correctly by people in the developing countries had been proved to be wrong, and HIV/AIDS-related work had demonstrated that the picture painted by development aid was not necessarily gloomy. The momentum already achieved should be maintained despite the current financial climate.

WHO’s role as set out in the draft strategy was clear: it made suggestions and recommendations that the Member States could use to design their own national strategies in the light of their history, culture and religion; it was moving away from monitoring and evaluation based on country comparisons, which took little account of differing socioeconomic situations.

All WHO guidelines were evidence-based. WHO was a technical agency; it acted on the basis of science. It gave Member States the best science it had, leaving them to determine their priorities on the basis of their capacities and financial possibilities. The Organization had no authority to enforce implementation. What was important was each country’s commitment to making progress, for HIV/AIDS was not just a health issue, but an economic, social and cultural issue that could compromise a country’s economic development.

The CHAIRMAN took it that the Executive Board wished to take note of the report. He suggested that, in view of the need to improve the draft strategy, the Secretariat should continue its dialogue with Board members on ways to achieve that aim in the coming week.

It was so agreed.

The meeting rose at 17:35.

FIFTH MEETING

Wednesday, 19 January 2011, at 09:10

Chairman: Dr M. KÖKÉNY (Hungary)

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

Health-related Millennium Development Goals: Item 4.4 of the Agenda (Document EB128/7) (continued)

The CHAIRMAN drew attention to a revised draft resolution on WHO's role in the follow-up to the high-level plenary meeting of the sixty-fifth session of the United Nations General Assembly on the review of the Millennium Development Goals (September 2010) proposed by Australia, Monaco, Norway, Senegal and Serbia, which read:

The Executive Board,

PP1 Having considered the report on health-related Millennium Development Goals;¹

PP2 Recalling resolutions WHA63.15 and WHA61.18 on monitoring of the achievement of the health-related Millennium Development Goals, and WHA63.24 on accelerated progress towards achievement of Millennium Development Goal 4 to reduce child mortality: prevention and treatment of pneumonia;

PP3 Expressing deep concern at the slow pace of progress in achieving Millennium Development Goals 4 and 5 on reducing child **and maternal** mortality ~~and improving maternal health~~;

PP3 (bis) Acknowledging that much more needs to be done in achieving the Millennium Development Goals as progress has been uneven among regions and between and within countries; despite the fact that developing countries have made significant efforts;

PP3 (ter) Recognizing the need to working towards greater transparency and accountability in international development cooperation, in both donor and developing countries, focusing on adequate and predictable financial resources as well as their improved quality and targeting;

PP4 Welcoming the Global Strategy for Women's and Children's Health launched at the United Nations High-level Plenary Meeting of the General Assembly on the Millennium Development Goals (New York, September 2010) and acknowledging the strong political and financial commitment by Member States to follow up and implement the strategy;

PP5 Noting the **United Nations** Secretary-General's request that WHO leads a process to determine the most effective international institutional arrangements for global reporting, oversight and accountability on women's and children's health, including through the United Nations system;

PP6 Stressing that monitoring of resource flows and results are vital requirements in the management of national health plans for improving the accountability and responsiveness by governments and international development partners;

¹ Document EB128/7.

PP7 Welcoming the establishment of the Commission on Information and Accountability for Women's and Children's Health, which consists of high-level representatives;

PP8 Noting that the objectives of the Commission are to:

- (1) determine international institutional arrangements for global reporting, oversight and accountability on women's and children's health. This accountability framework will encompass results and resources, and identify the roles of the different partners involved;
- (2) identify ways to improve monitoring of progress towards women's and children's health while minimizing the reporting burden on countries, including a set of core indicators, efficient investment in data generation and better data sharing;
- (3) propose actions to overcome major challenges to accountability at the country level, including strengthening of country capacity and addressing major data gaps such as the monitoring of vital events;
- (4) identify opportunities for innovation provided by information technology that will facilitate improved accountability for results and resources, and propose ways of ensuring these opportunities are harnessed to bring maximum benefits to countries;

PP9 stressing that aspects related to **health** equity and rights should also be addressed **in efforts to achieve the Millennium Development Goals**;

PP10 Stressing that the Commission should take into account relevant existing data collections and existing performance indicators;

REQUESTS the Director-General:

- (1) to ensure the effective engagement of all key stake holders **in the work of the Commission**;
- (2) to report to the Sixty-fourth World Health Assembly on progress on the work of the Commission on Information and Accountability for Women's and Children's Health in connection with the agenda item concerning the Millennium Development Goals.

The financial and administrative implications of the draft resolution for the Secretariat were as set out previously.

The resolution was adopted, as amended.¹

Substandard/spurious/falsely-labelled/falsified/counterfeit medical products: Item 4.8 of the Agenda (Document EB128/11)

The CHAIRMAN said that, since the meeting of the working group on substandard/spurious/falsely-labelled/falsified/counterfeit medical products had been postponed to early 2011, the Board might wish to note the report without entering into substantive discussion.

Mr PRASAD (adviser to Mr Chandramouli, India), welcoming the change to the more accurate terminology for the title of the agenda item (from "Counterfeit medical products"), expressed concern at the eight months' delay in convening the working group agreed upon in decision WHA63(10) and which should have reported to the Board at its current session. The Health Assembly had also decided that the working group would examine WHO's relationship with the International Medical Products Anti-Counterfeiting Taskforce. He reiterated his country's concerns about that body, whose primary interest – enforcement of intellectual property rights – could divert WHO from its public health mandate. He expressed surprise that WHO had issued invitations to a meeting in Berlin in July–August 2010 with a theme closely similar to the one with which the working group had been mandated.

¹ Resolution EB128.R1.

Some countries were attempting to create a parallel platform through the Anti-Counterfeiting Trade Agreement that would circumvent multilateral forums and the flexibilities of the Agreement on Trade-Related Aspects of Intellectual Property Rights and deny developing countries any influence on the agenda. He repeated the concerns that India had raised in different forums. He also drew attention to the deliberate confusion created by some special interest groups between counterfeiting in its strict intellectual property law sense and the quality, safety and efficacy of medicines. India had given high priority to, and consistently promoted, access to medicines. In October 2010, Brazil, India and South Africa had organized a well-attended seminar in Geneva on falsified and substandard medicines. Copies of the outcome of the seminar could be made available to the working group. Member States had high expectations of the Secretariat's work on strengthening national health surveillance systems and drug regulatory authorities and on promoting access to medicines. Any shift of focus would be a matter of serious concern.

He called for the suspension of the work of the Taskforce pending acceptance of the working group's conclusions by Member States. The working group should be constituted expeditiously with an intensive programme of work that would enable it to report to the Sixty-fourth World Health Assembly.

Dr PÁVA (alternate to Dr Kökény, Hungary), speaking on behalf of the European Union, said that the safety, quality and efficacy of medical products were key components of a comprehensive health policy. The presence on the market of substandard/spurious/falsely-labelled/falsified/counterfeit medical products was a serious risk to public and individual health. The European Union supported the holding of the first meeting of the working group as soon as possible and would contribute to the discussions.

Dr ALI (alternate to Professor Haque, Bangladesh) supported the early convening of the working group, expressing regret at the postponement of the first meeting. He expressed appreciation for the Secretariat's support for improving the capacity of developing countries' regulatory authorities, including those in Bangladesh, in order to ensure the quality of medicines and to combat substandard/spurious/falsely-labelled/falsified/counterfeit medical products. The main aim should be to protect public health and satisfy ethical concerns. The debate among Member States could be helped if the definition of the undesirable products covered could be simplified, and if counterfeiting and quality control were dealt with separately. It was important to put a stop to counterfeiters, but it was essential to ensure that legitimate manufacturers of generic products were not at a disadvantage. He recalled the conclusion of the Regional Committee for South-East Asia at its sixty-first session (in September 2008), which emphasized the importance of the public health focus in combating counterfeit medical products and separating them from matters of intellectual property rights.¹

Dr OULD HORMA (Mauritania), speaking on behalf of the Member States of the African Region, agreed that counterfeit medicines represented a risk to public health. The magnitude of the problem was not known, but even a single case was unacceptable. In addition to harming health and threatening life, such products wasted precious resources, promoted antimicrobial resistance, and could undermine confidence in health systems. In low-income countries in the Region, national systems to regulate pharmaceuticals were absent or functioned poorly, providing ample opportunities for the production and distribution of counterfeit products. WHO and the International Criminal Police Organization had organized a regional conference (IMPACT regional conference on combating counterfeit medical products, Johannesburg, South Africa, 8–9 November 2009). The participants had considered the need to establish a legal framework to support appropriate legal procedures, to establish

¹ Report of the Sixty-first Session of the Regional Committee for South-East Asia, paragraph 178:
http://www.searo.who.int/EN/Section1430/Section1439/Section1638/Section2525_14675.htm (accessed January 2011).

national multiagency working groups with international links to the International Medical Products Anti-Counterfeiting Taskforce, and to ensure the implementation of relevant legislation.

Following decision WHA63(10), the Regional Office for Africa had established a regional working group to examine the current situation and recommend appropriate actions to combat substandard/spurious/falsely-labelled/falsified/counterfeit medical products. Its proposals, which had been adopted by the Regional Committee for Africa at its sixtieth session in September 2010,¹ included the establishment of an African agency for the regulation of pharmaceuticals at the regional, subregional and national levels.

Mrs ESCOREL DE MORAES (adviser to Dr Buss, Brazil) endorsed the comments made by the member for India. Too much time had already been wasted and the working group should have commenced its work long before. Remaining difficulties should be resolved at the current Board session so that the working group could begin its deliberations as soon as possible. She understood that its first meeting was scheduled to start on 28 February 2011.

Dr DAULAIRE (United States of America) said that all countries shared the same interest in seeking to protect the health of their citizens. It was therefore vital to raise awareness at the highest political level of the negative impacts of substandard/spurious/falsely-labelled/falsified/counterfeit medical products and of the complexities and reduced transparency of the global supply chain. There was also a need to build global monitoring and surveillance systems to assist in identifying areas of public health risk. The United States paid serious attention to all reports of compromised medical products, devoting the necessary resources to investigation and follow-up, and initiating appropriate actions including recalls, public-awareness campaigns and collaboration with international regulation and law enforcement organizations. The global community must join forces through anti-counterfeiting technologies, well-functioning regulatory systems, and networks for collecting, sharing and analysing information. The United States was committed to continuing collaboration with its partners around the world, including WHO and the International Medical Products Anti-Counterfeiting Taskforce, whose work it strongly supported, with a view to strengthening capacity to produce high-quality medicines and to combat substandard/spurious/falsely-labelled/falsified/counterfeit medical products. He urged capitalizing on expertise around the world in those areas, and welcomed the fact that the working group process was finally beginning.

Mrs YAHAYA (Nigeria)² recalled resolutions WHA41.16 on the rational use of drugs and resolution WHA52.19 on revised drug strategy, which had given WHO a clear mandate to develop strategies to combat substandard/spurious/falsely-labelled/falsified/counterfeit medical products and to ensure access to safe, effective and affordable medicines. However, lack of agreement on the definition of compromised medical products had hampered deliberations at the Sixty-third World Health Assembly and, while the working group had yet to meet, counterfeiters were free to continue making huge profits at the expense of poor populations in developing countries. All stakeholders needed to work together at national, regional and international levels to fight against substandard/spurious/falsely-labelled/falsified/counterfeit medical products. She therefore acknowledged the role of the International Medical Products Anti-Counterfeiting Taskforce and supported the regional action agreed by the Regional Committee for Africa at its sixtieth session in September 2010.

Mrs MATSAU (South Africa),² endorsing the comments made by the members for India and Brazil, asked about the scheduled dates for the first meeting of the working group. It would be

¹ Document AFR/RC60/21.

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

important for Member States to receive the group's report well before the Sixty-fourth World Health Assembly in May 2011.

Dr NARVÁEZ (Ecuador) said that substandard/spurious/falsely-labelled/falsified/counterfeit medical products were a threat to health and a serious concern to the member countries of the South American Health Council, whose Members awaited the outcome of the working group's deliberations. However, the fight against compromised medical products should not detract from the fact that Member States were primarily responsible for establishing relevant policies and for ensuring access to safe and effective medicines of high quality. Member States should give the matter priority, as agreed at the Sixty-third World Health Assembly, and deal with it in a timely manner.

Mr JAFRI (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, said that his organization gave priority to the fight against the proliferation of counterfeit medicines, which represented a risk to health and threatened to erode trust in health-care systems. Urgent action was required and WHO had a central role to play in bringing together relevant stakeholders. A global approach was essential in order to prevent counterfeit medicines harming patients in the poorest and least protected areas, and to empower them through information, choice and solutions. His organization reaffirmed its commitment to action through WHO, the International Medical Products Anti-Counterfeiting Taskforce and other related bodies.

The DIRECTOR-GENERAL reaffirmed WHO's focus on public health and the implementation of policy decisions on support for the production and use of high-quality generic medicines. The Secretariat was working closely with many Member States to strengthen their national quality control and regulatory mechanisms in order to ensure access to safe and effective medicines of high quality and avoid threats from substandard/spurious/falsely-labelled/falsified/counterfeit medical products. The definition of such products had clearly created problems and she awaited guidance from the working group, which she would do her utmost to support. The first meeting of the group would be held from 28 February to 2 March 2011.

The Board noted the report.

Health system strengthening: Item 4.5 of the Agenda (Documents EB128/8 and EB128/37) (continued)

The CHAIRMAN said that, in addition to the two reports, five draft resolutions had been tabled: on sustainable health financing structures and universal coverage, proposed by Germany on behalf of the 27 Member States of the European Union and Switzerland; on health workforce strengthening, proposed by Japan and Norway; on strengthening national health emergency and disaster management capacities and resilience of health systems, proposed by Chile; on strengthening nursing and midwifery, proposed by Burundi and Kenya; and on strengthening national policy dialogue to build more robust health policies, strategies and plans, proposed by India.

Dr PÁVA (alternate to Dr Kökény, Hungary), speaking on behalf of the European Union, indicated that the candidate countries Turkey, Croatia, The former Yugoslav Republic of Macedonia and Iceland, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, and the Republic of Moldova, Armenia and Georgia aligned themselves with her statement. Universality, access to good-quality care, equity and solidarity were the overarching values adopted by the European Union in Council conclusions on common values and principles in European Union health systems. The Tallinn Charter: Health systems for health and wealth was perceived as a turning point in the development of a strategic framework for strengthening health systems.

Health systems had to maintain sufficient resourcing of, and capacity for, public health functions, including epidemiological surveillance, health protection, advocacy for health in all policies, which would be of particular importance in tackling noncommunicable diseases, planning,

and governance. Much of the world's population still had no access to health care or faced unaffordable expenditure on direct out-of-pocket payments for health services and medicines. Decisions on financing of health systems were crucial in ensuring effective and equitable access to health services. *The world health report 2010*¹ had highlighted the need to shift away from direct out-of-pocket payments towards systems of prepayment and pooling of financial risk that reduced financial barriers to health care.

The European Union remained committed to fair and sustainable financing structures and had therefore, on the initiative of Germany, submitted a draft resolution on sustainable financing structures and universal coverage, which read:

The Executive Board,
Having considered the reports on health systems strengthening,²

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

The Sixty-fourth World Health Assembly,
Having considered *The world health report 2010*,¹ which received strong support from the Ministerial Conference on Health Systems Financing – Key to Universal Coverage (Berlin, November 2010);

PP1 Recalling resolution WHA58.33 on sustainable health financing, universal coverage and social health insurance;

PP2 Acknowledging that health and social protection are essential human rights;

PP3 Recognizing that effective health systems delivering comprehensive health services, including preventive services, are of utmost importance for health, economic development and well-being and that these systems need to be based on equitable and sustainable financing as mentioned in the 2008 WHO Tallinn Charter on “Health systems for health and wealth”;

PP4 Underlining the valuable contribution made by fair and sustainable financing structures to the achievement of the health-related Millennium Development Goals 4 (Reduce child mortality); 5 (Improve maternal health); 6 (Combat HIV/AIDS, malaria and other diseases); as well as to Goal 1 (Eradicate extreme poverty and hunger);

PP5 Having considered *The world health report 2008*,³ and resolution WHA62.12 that highlighted universal coverage as one of the four key pillars of primary health care through patient-centred care, inclusive leadership and health in all policies;

PP6 Noting that health-financing structures in many countries need to be further developed in order to guarantee access to necessary health services for all while preventing and providing protection against disastrous financial risks;

PP7 Accepting that, irrespective of the source of financing for the health system selected, equitable prepayment and pooling of resources and risks, and the avoidance of significant direct payments at the point of delivery, are basic principles for achieving universal social protection in health;

PP8 Considering that the choice of a health-financing system should be made within the particular context of each country, while the core functions revenue collection,

¹ *The world health report 2010. Health systems financing: the path to universal coverage*. Geneva, World Health Organization, 2010.

² Documents EB128/8 and EB128/37.

³ *The world health report 2008. Primary health care: now more than ever*. Geneva, World Health Organization, 2008.

risk pooling, purchasing, and delivery of basic services are important to be regulated and maintained;

PP9 Acknowledging that a number of Member States are pursuing health-financing reforms that may involve a mix of public and private approaches, and a financing mix of contribution-based and tax-financed inputs;

PP10 Recognizing the important role of state legislative and executive bodies, and civil society, in further reform of health-financing systems with a view to achieving universal coverage,

1. URGES Member States:¹

- (1) to ensure that health-financing systems evolve so as to avoid over-reliance on significant direct payments at the point of delivery, and include a method for prepayment of financial contributions for health care, as well as a mechanism to pool risks among the population in order to avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking the care needed;
- (2) to aim for universal coverage and access for all on the basis of equity and solidarity, so as to provide an adequate scope of health services and level of costs covered, as well as comprehensive and affordable preventive services;
- (3) to ensure that external funds for specific health interventions do not distort the attention given to health priorities in the country, that they increasingly comply with the principles of aid effectiveness, and that they contribute in a predictable way to the sustainability of financing;
- (4) to plan their health systems transition to universal coverage, while continuing to safeguard the quality of services and to meet the needs of the population in order to reduce poverty and to attain internationally agreed development goals, including the Millennium Development Goals;
- (5) to recognize that, when managing the transition to universal coverage, each option will need to be developed within the particular epidemiological, macroeconomic, sociocultural and political context of each country;
- (6) to take advantage, where appropriate, of opportunities that exist for collaboration between public and private providers and health-financing organizations, under strong overall government-inclusive stewardship;
- (7) to promote the efficiency, transparency and accountability of health-financing systems;
- (8) to ensure that overall resource allocation strikes an appropriate balance between health promotion, disease prevention, and health-care provision;
- (9) to share experiences and important lessons learnt at the international level for encouraging country efforts, supporting decision-makers, and boosting reform processes;

2. REQUESTS the Director-General:

- (1) to provide a report on measures taken and progress made in the implementation of resolution WHA58.33, especially in regard to equitable and sustainable health financing and social protection of health in Member States;
- (2) to prepare a plan of action for WHO to support Member States in realizing universal coverage as envisaged by resolution WHA62.12 and *The world health report 2010*;²

¹ And regional economic integration organizations where appropriate.

² *The world health report 2010. Health systems financing: the path to universal coverage*, Geneva, World Health Organization, 2010.

- (3) to provide, in response to requests from Member States, technical support for strengthening capacities and expertise in the development of health-financing systems, particularly equitable prepayment schemes, with a view to achieving universal coverage by providing comprehensive health services for all;
- (4) to facilitate within existing forums continuous sharing of experiences and lessons learnt on social health protection and universal coverage;
- (5) to report back to the Sixty-fifth World Health Assembly and thereafter every three years, through the Executive Board, on the implementation of this resolution, including on outstanding issues raised by Member States during the Sixty-fourth World Health Assembly.

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

1. Resolution Sustainable health financing structures and universal coverage	
2. Linkage to programme budget	
Strategic objective: 10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.	<p>Organization-wide expected result: All the Organization-wide expected results under strategic objective 10, particularly:</p> <p>10.10 Evidence-based policy and technical support provided to Member States in order to improve health-system financing in terms of the availability of funds, social and financial-risk protection, equity, access to services and efficiency of resource use.</p> <p>10.11 Norms, standards and measurement tools developed for tracking resources, estimating the economic consequences of illness, and the costs and effects of interventions, financial catastrophe, impoverishment, and social exclusion, and their use supported and monitored.</p> <p>10.12 Steps taken to advocate additional funds for health where necessary; to build capacity in framing of health-financing policy and interpretation and use of financial information; and to stimulate the generation and translation of knowledge to support policy development.</p>
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The resolution provides a framework that will contribute to the achievement of the expected results mentioned above and links to the relevant indicators, targets and baselines.	
3. Budgetary implications	
(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).	
Implementation of the resolution will entail costs of US\$ 9 million over the next six years, in addition to the cost of US\$ 4.8 million estimated for implementation of resolution WHA62.12. This figure represents the cost of: scaling up technical and policy support to Member States in the area of health financing for universal coverage; linking this effort with national health plans and strategies; and increasing capacity to share experiences across countries.	

- (b) Estimated cost for the biennium 2010–2011 (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)**

All levels of the Organization are currently engaged in the provision of technical support to countries in relation to financing for universal coverage; they all facilitate the sharing of experiences across countries. The cost of scaling up these activities in order to meet the current demand from countries, as well as the need to share across countries information on what has worked and what has not worked, is estimated at US\$ 1.5 million during 2011 (US\$ 1.05 million for the regions and US\$ 450 000 for headquarters).

- (c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?**

Some costs for technical support to countries and information sharing were included in the Programme budget 2010–2011. The costs outlined here are additional costs required to meet the growing demand for countries for this type of support partly in response to *The world health report 2010*.¹

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

A strategy for mobilizing the additional resources required in a resource-constrained environment is being developed.

5. Administrative implications

- (a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).**

All regions will engage in providing technical support to Member States. Headquarters will support this effort, helping to coordinate increased exchange of information as requested by the resolution – particularly since there is increasing demand for cross-regional exchanges. However, regional and country offices will also be heavily involved in information-exchange activities.

- (b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.**

In order to meet the expected increase in demand from Member States for this type of support, new staff will be required or existing staff will need to be redeployed. Many regional and country offices do not have sufficient skills in health financing.

- (c) 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).**

The costs mentioned above include additional staff in the professional category in the area of health financing policy (1.5 at headquarters and 3 in the regions).

- (d) Time frames (indicate broad time frames for implementation of activities).**

Health financing systems are always developing so requests for technical support will continue. The time frame for this costing is set at three bienniums (six years).

The draft resolution built on *The world health report 2010* and resolution WHA58.33 on sustainable health financing, universal coverage and social health insurance. It underlined the contribution appropriate financing structures could make to the attainment of Millennium Development Goals 1, 4, 5 and 6, and requested the Director-General to prepare a plan of action for

¹ *The world health report 2010. Health systems financing: the path to universal coverage*. Geneva, World Health Organization, 2010.

providing support to Member States in realizing universal coverage, including technical support for strengthening national capacities for developing health financing systems.

She wished to propose some amendments to the other draft resolutions tabled under the agenda item, which would be submitted to the proposers and the Secretariat in writing.

Mr LARSEN (Norway) introduced a draft resolution on health workforce strengthening, proposed by Norway and Japan, which read:

The Executive Board,
Having considered the reports on health system strengthening,¹

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

The Sixty-fourth World Health Assembly,

PP1 Recalling resolution WHA57.19 on challenges posed by the international migration of health personnel, which, inter alia, urged Member States to develop strategies to mitigate the adverse effects of migration of health personnel and minimize its negative impact on health systems, and to frame and implement policies that could enhance effective retention of health personnel;

PP2 Recalling also resolution WHA59.23 on rapid scaling up of health workforce production, which, inter alia, recognized that shortages of health workers are interfering with efforts to achieve the internationally agreed health-related development goals, including those contained in the Millennium Declaration, and those of WHO's priority programmes;

PP3 Taking note of the WHO Global Code of Practice on the International Recruitment of Health Personnel,² which, inter alia, recognized that an adequate and accessible health workforce is fundamental to an integrated and effective health system and for the provision of health services, and that Member States should take measures to educate, retain and sustain a health workforce that is appropriate for the specific conditions of each country;

PP4 Noting with approval recent international calls to action regarding the importance of ensuring scale-up and an equitable distribution of the health workforce globally, regionally and within countries;³

PP5 Recognizing the centrality of human resources for health for the effective operation of health systems as highlighted in *The world health report 2006*,⁴ and that the health workforce shortages and inefficiencies are also seriously hampering effective

¹ Documents EB128/8 and EB128/37.

² Adopted in resolution WHA63.16.

³ Including, but not limited to, *the Kampala Declaration and Agenda for Global Action of March 2008*; the G8 Communiqué of July 2008; *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 High-level Taskforce on Innovative International Financing for Health Systems, 2009; and the *Venice concluding statement on maximising positive synergies between health systems and Global Health Initiatives*, 2009.

⁴ *The world health report 2006 – working together for health*; Geneva. World Health Organization, 2006.

implementation of primary health care, as stated in *The world health report 2008*,¹ and expansion of health service coverage, as described in *The world health report 2010*;²

PP6 Deeply concerned that shortages and inadequate distribution of appropriately trained and motivated health workers, and inefficiencies in the ways in which the health workforce is managed and utilized, remain major impediments to the effective functioning of health systems and constitute one of the main bottlenecks to achieving the health-related Millennium Development Goals;

PP7 Realizing that increased production and improved retention of health workers is reliant on a sufficient and sustainable health financing system, which is to some extent determined by decisions made outside the confines of the health sector, including in international organizations;

PP8 Taking into account that disease-specific programmes established by nongovernmental organizations, international organizations, development organizations and other relevant organizations working in developing countries, while on balance having a positive effect, may in fact increase the burden on the existing health workforce and contribute to attrition of the health workforce from the public sector;

PP9 Observing that insufficient evidence on the effectiveness of health workforce policies and a lack of comprehensive, reliable and up-to-date data, including analytical tools, constitute significant challenges for Member States trying to achieve or maintain a sufficient, sustainable and effective health workforce;

PP10 Concerned that many Member States, particularly those with critical shortages or imbalances of health workers, also lack the governance, technical and managerial capacity to design and implement efficient and effective policy interventions related to scaling up and retaining the health workforce;

PP11 Realizing that a sufficient, efficient and sustainable health workforce is at the heart of robust health systems and a prerequisite for sustainable health improvement,

1. URGES Member States:

- (1) to implement the WHO Global Code of Practice on the International Recruitment of Health Personnel in order that both source and destination countries may derive benefits from the international migration of health personnel and in order to mitigate the negative effects of health worker migration on health systems, particularly in countries with critical health worker shortages;
- (2) to prioritize, in the context of the global economic context, public sector spending on health, as appropriate, to ensure that sufficient financial resources are available for the implementation of policies and strategies to scale-up and retain the health workforce, particularly in developing countries, and to recognize it as investment for growth;
- (3) to develop or maintain a national health workforce plan as an integral part of a validated national health plan, with increased efforts towards effective implementation and monitoring;
- (4) to use evidence-based findings and strategies, including from the Global Health Workforce Alliance Taskforce on Scaling Up Education and Training, for the successful scaling-up of health worker education and training;
- (5) to develop strategies and policies to increase the availability of motivated and skilled health workers in remote and rural areas, including the evidence-based

¹ *The world health report 2008. Primary health care: now more than ever*. Geneva, World Health Organization, 2008.

² *The world health report 2010. Health systems financing: the path to universal coverage*. Geneva, World Health Organization, 2010.

WHO global policy recommendations on increasing access to health workers in remote and rural areas through improved retention of the health workforce;

(6) to develop or strengthen in-country capacity for health workforce information systems including the collection, processing and disseminating of information on their health workforce, including, but not limited to, stock, education and training capacity, distribution, migration and expenditures; in order to guide, accelerate and improve country action;

(7) to address other factors that affect the availability of health workers in rural or remote areas, such as socioeconomic deprivation, geographical barriers and distance, transport and the acceptability of services;

2. URGES nongovernmental organizations, international organizations, international donor agencies, financial and development institutions and other relevant organizations working in developing countries:

(1) to align and harmonize, in line with the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, their education, training, recruitment and employment practices with those of the countries in which they are based, in particular national health plans, where available, in order to create synergies and support Member States' efforts at building a sustainable health workforce, strengthen health systems and improving health outcomes;

(2) to support national long-term strategies and interventions to build and sustain a sufficient and efficient health workforce, including investing in the future health workforce by providing funds for education, training and retention;

3. REQUESTS the Director-General:

(1) to continue the implementation of the Global Code of Practice on the International Recruitment of Health Personnel, including, upon request, provision of technical support to Member States in implementing the Global Code;

(2) to provide leadership at global and regional levels by highlighting solutions and giving visibility to issues that hinder access to health workers; to work closely with partner agencies in the multilateral system on appropriate measures to support Member States' efforts to maintain or achieve a sufficient, sustainable and effective workforce; and to advocate for this topic to be high on global development and research agendas;

(3) to provide technical support to Member States, upon request, for their efforts to scale-up education and training and improve the retention of the health workforce; including identifying efficient and effective health workforce policies and developing and implementing national health workforce plans;

(4) to support Member States, upon request, to strengthen their capacity for coordination on health workforce issues between Ministries of Health, other Ministries and other relevant stakeholders;

(5) to encourage and support Member States in developing and maintaining a framework for health workforce information systems, in order to accommodate the collection, processing and dissemination of information on their health workforce, including stock, migration, education and training capacity, skill mix, distribution, expenditures, positions and determinants of change;

(6) to encourage Member States to support the ongoing development of the WHO policy guidelines on transformative scale-up of health professional education in order to increase the quantity, quality and relevance of the health workforce, and towards addressing shortages in human resources for health in an equitable and efficient manner.

(7) to promote research relevant for both developing and developed countries on efficient and effective policies and interventions to improve scale-up and retention

of the health workforce, with the aim of establishing and maintaining an accessible global evidence base for best practice, and efficient and effective health workforce policies and interventions, including supporting the development and strengthening of knowledge centres with the purpose of accommodating translation of evidence and best practice into context-specific policy solutions;

(8) to strengthen capacity within the Secretariat with the purpose of giving sufficient priority to relevant tasks related to the Organization's wider efforts in addressing the global health workforce crisis;

(9) to report on progress in implementing this resolution to the World Health Assembly through the Executive Board, in a manner integrated with the reporting on resolution WHA63.16 on the WHO Global Code of Practice on the International Recruitment of Health Personnel.

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

1. Resolution Health workforce strengthening	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected result:
10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.	10.8 Health-workforce information and knowledge base strengthened, and country capacities for policy analysis, planning, implementation, information-sharing and research built up.
	10.9 Technical support provided to Member States, with a focus on those facing severe health-workforce difficulties in order to improve the production, distribution, skill mix and retention of the health workforce.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
WHO's activities in support of health workforce strengthening have links with strategic objective 10, specifically the two Organization-wide expected results mentioned above. The present resolution is also linked to the implementation of resolution WHA63.16, in which (inter alia) the WHO Global Code of Practice on the International Recruitment of Health Personnel was adopted.	
3. Budgetary implications	
(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities). US\$ 39 million over a period of six years, beginning 2011. This includes activities at headquarters and in the regions.	
(b) Estimated cost for the biennium 2010–2011 (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\$ 1.5 million at headquarters level and US\$ 4.5 million at regional level.	
(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011? A total of US\$ 1 million is included for headquarters and the regions.	

4. Financial implications**How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?**

Costs will be met through income from core voluntary contributions from Member States and international partners. In line with the implementation strategy for the Code developed by the Secretariat, resource mobilization activities will be undertaken for this area with a particular focus on certain Member States and international partners, since this is a mission-critical activity. Indications of support have already been received from the European Union, Japan, Norway and the United States of America.

5. Administrative implications**(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 will be involved; however, implementation will particularly concern countries facing major challenges as a result of critical health workforce shortages.

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.

No. Additional staff will be required at headquarters and in the regions.

(c) 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).

Exact requirements will depend on the intensity of activities. Every effort will be made to make full use of secondments and the deployment of interns, in addition to employing short-term staff.

(d) Time frames (indicate broad time frames for implementation of activities).

An implementation strategy has already been developed by the Secretariat. Activities will be implemented according to this strategy, which covers the period 2011–2015.

Insufficient health workers were being trained and the distribution of health workers remained inequitable. Moreover, the increasingly global nature of the labour market was exacerbating the flow from developing to developed countries. The WHO Global Code of Practice on the International Recruitment of Health Personnel, adopted by the Health Assembly in resolution WHA63.16, should mitigate the negative effects of health worker migration on national health systems. The draft resolution aimed to reinforce the efforts of Member States and the Secretariat to expand workforce training and to ensure a distribution of health workers that yielded the best possible health outcomes, regardless of geographical location. The Secretariat's role required strengthening given that the reporting requirements related to resolution WHA59.23 on the rapid scale-up of health workforce production had expired. It was hoped that the proposed draft resolution and the Global Code would provide a comprehensive mandate for the Secretariat to continue its work in the area and that the text was sufficiently balanced to accommodate the diverse needs of Member States.

Norway supported the draft resolutions on strengthening nursing and midwifery, sustainable health financing structures and universal coverage, and strengthening national health emergency and disaster management capacities and resilience of health systems. In Norway's experience, universal coverage was best achieved through universal, mandatory and redistributive forms of revenue collection, risk pooling at population level, and the limiting of levels of direct payment. As reflected in *The world health report 2010*, individuals should contribute to the system based on ability to pay and should have access to services based on need.

Mr PRASAD (adviser to Mr Chandramouli, India) said that robust health systems were essential for the attainment of the health-related Millennium Development Goals and reforms. Policies needed to be adjusted if health systems were to respond better to health challenges. India's efforts to provide equitable access through targeted interventions under its National Rural Health Mission 2005–2012

had reduced direct payment for services, which was a major cause of impoverishment. Further initiatives were under way to increase the number of doctors and paramedical staff, to raise production of generic medicines, and to regulate the private sector. Although document EB128/37 referred to the Global Code, he sought further information on progress in its implementation and impact in developing countries. In respect of voluntary contributions, he would also have liked to see an analysis of disease-specific funding bodies and their effect on national health policies, health system programming and health workforce distribution.

Having considered document EB128/8, India also proposed a draft resolution, on strengthening national policy dialogue to build more robust health policies, strategies and plans, which read:

The Executive Board,

Having considered the report on health system strengthening: improving support to policy dialogue around national health policies, strategies and plans,¹

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

The Sixty-fourth World Health Assembly,

PP1 Having considered the importance of policy directions suggested by the world health reports for 2008 and 2010;^{2,3} resolution WHA62.12 on primary health care, including health systems strengthening; resolutions EUR/RC60/R5 on addressing key public health and health policy challenges in Europe: moving forwards in the quest for better health in the WHO European Region; WPR/RC61.R2 on the Western Pacific Regional Strategy for health systems based on the values of primary health care; AFR/RC60/R1 on a strategy for addressing key determinants of health in the African Region and documents AFR/RC60/7 on health systems strengthening: improving district health service delivery, and community ownership and participation and SEA/RC63/9 on development of national health plans and strategies;

PP2 Recognizing that robust and realistic national health policies, strategies and plans are key in strengthening health systems based on primary health care;

PP3 Underlining the importance of coherent and balanced policies, strategies and plans under ministries of health vis-à-vis consolidating efforts to reach the Millennium Development Goals;

PP4 Acknowledging that many Member States have made efforts to ensure that their national health policies, strategies and plans respond better to growing expectations for improved health and better services;

PP5 Noting that an inclusive policy dialogue with a comprehensive range of stakeholders, within and beyond government, within the health sector and other health-related activities of other sectors, is critical to increasing the likelihood that national policies, strategies and plans will be appropriately designed and implemented and will yield the expected results,

¹ Document EB128/8.

² *The world health report 2008: primary health care (now more than ever)*. Geneva, World Health Organization, 2008.

³ *The world health report 2010: health systems financing: the path to universal coverage*. Geneva, World Health Organization, 2010.

1. URGES Member States:
 - (1) to show effective leadership and ownership of the process of establishing robust national health policies and strategies, basing that process on broad and continuous consultation of relevant stakeholders, within and outside the public sector;
 - (2) to base their national health policies, strategies and plans on the overarching goals of universal coverage, people-centred primary care and health in all policies, as well as on a comprehensive, balanced and evidence-based assessment of the country's health and health system challenges;
 - (3) to ensure that national health policy, strategies and plans are both ambitious and realistic with respect to available resources and the capacities of staff and institutions, and that they address the entire health sector, public as well as private, as well as the social determinants of health;
 - (4) to pre-empt disconnection between the national health policies strategies and plans; the subnational operational plans, disease or life-cycle programmes; and the country's overall development and political agenda;
 - (5) to regularly monitor, review and adjust their national health policies, strategies and plans with a view to adjusting them to respond to evolving challenges and opportunities, and to ensure that such reviews involve all relevant stakeholders;
2. CALLS upon development agencies to strengthen adherence to the principles of the Paris Declaration on Aid Effectiveness, of alignment, harmonization, country ownership and managing for results, privileging "joined up" efforts through mechanisms such as the International Health Partnership;
3. REQUESTS the Director-General:
 - (1) to renew the Organization's emphasis on its role at country level as a facilitator of inclusive policy dialogue around national health policies, strategies and plans, and to reflect this across the Organization's workplans and operations;
 - (2) to ensure national policy dialogue receives continued technical inputs for conducting the planning process, particularly at key moments of formulation and review;
 - (3) to use the Organization's leverage to promote effective adherence of development agencies to the principles of the Paris Declaration on Aid Effectiveness, of alignment, harmonization, country ownership and managing for results based on priorities set out in the national health policies, strategies and plans;
 - (4) to ensure continuity of support to Member States and assist Member States in ensuring the quality of the technical support they receive;
 - (5) to build up the Organization's capacity at all levels for enhanced and integrated support to national policy dialogue around national health policies, strategies and plans;
 - (6) to report to the next Executive Board/World Health Assembly on progress made, obstacles faced and results obtained in enhancing support provided to Member States to national policy dialogue around national health policies, strategies and plans.

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

1. Resolution Strengthening national policy dialogue to build more robust health policies, strategies and plans for the 128th Executive Board and the Sixty-fourth World Health Assembly	
2. Linkage to programme budget <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>Strategic objective:</p> <p>10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.</p> </div> <div style="width: 45%;"> <p>Organization-wide expected result:</p> <p>10.1 Management and organization of integrated, population-based health-service delivery through public and nonpublic providers and networks improved, reflecting the primary health care strategy, scaling up coverage, equity, quality and safety of personal and population-based health services, and enhancing health outcomes.</p> <p>10.2 National capacities for governance and leadership improved through evidence-based policy dialogue, institutional capacity-building for policy analysis and development, strategy-based health system performance assessment, greater transparency and accountability for performance, and more effective intersectoral collaboration.</p> <p>10.3 Coordination of the various mechanisms (including donor assistance) that provide support to Member States in their efforts to achieve national targets for health-system development and global health goals improved.</p> </div> </div> <p style="text-align: center;">(Briefly indicate the linkage with expected results, indicators, targets, baseline)</p> <p>This resolution is linked to resolution WHA62.12 on primary health care, including health system strengthening.</p>	
3. Budgetary implications <p>(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 50 million over a period of six years.</p> <p>(b) Estimated cost for the biennium 2010–2011 (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\$ 8 million at all levels of the Organization.</p> <p>(c) Is the estimated cost noted in (b) included within the existing approved Programme budget for the biennium 2010–2011? Yes.</p>	
4. Financial implications <p>How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?</p> <p>Costs will be met through income from voluntary contributions from Member States and contributions from international partners.</p>	
5. Administrative implications <p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)</p> <p>All levels of the Organization will be involved.</p>	

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below No

(c) 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)

Exact requirements will depend on the intensity of activities. Every effort will be made to make full use of secondments in addition to employing short-term staff.

(d) Time frames (indicate broad time frames for implementation of activities)

The Secretariat is drawing up implementation plans.

The draft resolution called for the intensification of efforts to strengthen national health plans, strategies and policies, which were crucial to collective, comprehensive action to attain universal coverage.

Dr JADUE (Chile) introduced a draft resolution on strengthening national health emergency and disaster management capacities and resilience of health systems, which read:

The Executive Board,

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

The Sixty-fourth World Health Assembly,

PP1 Recalling resolutions WHA58.1 and WHA59.22 on emergency preparedness and response, resolution WHA61.19 on climate change and health, and other World Health Assembly and Regional Committee resolutions and action plans on health security, international health regulations, pandemic preparedness, safe hospitals and other matters related to emergencies and disasters at local and national levels;

PP2 Recalling United Nations' General Assembly Resolutions 60/195, 61/198, 62/192, 63/216, 64/200 and 64/251, which calls upon Member States to increase efforts to implement the *Hyogo Framework for Action 2005–2015: Building the Resilience of Nations and Communities to Disasters*, to strengthen risk reduction and emergency preparedness measures at all levels, and to encourage the international community and relevant United Nations' entities to support national efforts aimed at strengthening capacity to prepare for and respond to disasters;

PP3 Reaffirming that countries have responsibility for ensuring the protection of the health, safety and welfare of their people and for ensuring the resilience and self-reliance of the health system, which is critical for minimizing health hazards and vulnerabilities and delivering effective response and recovery in emergencies and disasters;

PP4 Regretting the tragic and enormous loss of life, injuries, disease and disabilities resulting from emergencies, disasters and crises of all descriptions;

PP5 Mindful that emergencies and disasters also result in damage and destruction of hospitals and other health infrastructure, weaken the ability of health systems to deliver health services; and setbacks for health development and the achievement of the Millennium Development Goals;

PP6 Expressing deep concern that continuing poverty, increasing urbanisation and climate change are expected to increase the health risks and impacts of emergencies and disasters on many countries and communities;

PP7 Acknowledging that most action to manage the risks to health from natural, biological, technological and societal hazards, including the immediate emergency

response, are provided by local and country level actors across all health disciplines, including mass casualty management, mental health and non-communicable diseases, communicable diseases, environmental health, maternal and new-born health, reproductive health, nutrition and cross-cutting health issues;

PP8 Recognizing the contribution of other sectors and disciplines to the health and well-being of people at risk of emergencies and disasters, including local government, planners, architects, engineers, emergency services and civil protection, and academia;

PP9 Concerned that country and community capacities to manage major emergencies and disasters are often overwhelmed, and that coordination, communications and logistics are often revealed as the weakest aspects of health emergency management;

PP10 Appreciating that some countries, including those with low income or emerging country development status, have reduced mortality and morbidity in disaster situations due to investment in emergency and disaster risk reduction measures, with the support of local, regional and global partners;

PP11 Recognizing that WHO works closely with other members of the international community, such as the United Nations Secretariat of the International Strategy for Disaster Reduction, United Nations Development Programme, UNICEF, UN-OCHA, Red Cross/Red Crescent Movement and nongovernmental organizations, on supporting country capacity development and developing institutional capacities for multisectoral emergency and disaster management;

PP12 Building on the International Strategy for Disaster Reduction 2008–2009 World Disaster Reduction campaign on Hospitals Safe from Disasters, and the 2010–2011 campaign on Disaster Resilient Cities, World Health Day 2008 on Climate Change and Health, World Health Day 2009 on Hospitals Safe in Emergencies and World Health Day 2010 on Urban Health Matters, which have resulted in local, national and global action on reducing risks to health from emergencies and disasters;

PP13 Recognizing that improved health outcomes from emergencies and disasters require urgent additional action at country, regional and global levels to ensure that the local and national health risk reduction and overall response in emergencies and disasters is timely and effective and that health services remain operational when they are most needed,

1. URGES Member States to:

- (1) strengthen all-hazards health emergency and disaster risk management programmes as part of national health systems to improve health outcomes, reduce mortality and morbidity, protect investment in health infrastructure and strengthen the resilience of the health system and society at large;
- (2) integrate all-hazards health emergency and disaster risk management programmes into National Health Plans and institutionalize capacities for coordinated health and multisectoral action to assess risks, proactively reduce risks, prepare for, respond to, and recover from, emergencies, disasters and other crises;
- (3) develop safe and prepared hospitals programmes which ensure that new hospitals and health facilities are located and built safely to withstand local hazards, that the safety of existing facilities is assessed and remedial action is taken, and that all health facilities are prepared to respond to internal and external emergencies;
- (4) promote regional and subregional collaboration, including sharing of experience and expertise for capacity development, as well as in risk reduction, response and recovery;
- (5) strengthen the role of local health workforce in the health emergency management system to provide local leadership and health services, through enhanced planning, training, and access to other resources;

2. REQUESTS the Director General to:
 - (1) ensure WHO at all levels has enhanced capacity and resources, and optimizes its expertise across all disciplines in the Organization, in order to provide the necessary technical guidance and support to Member States and partners, for developing health emergency and disaster risk management programmes at national and local levels;
 - (2) strengthen collaboration with relevant entities, including public, private, non-government and academia to support country and community health emergency and disaster risk management;
 - (3) strengthen the evidence base for health emergency and disaster risk management, including operational research and economic assessments;
 - (4) support national assessments of risks and capacities for health emergency and disaster risk management, as a basis for catalysing action and strengthening national health emergency and disaster risk management capacities;
 - (5) provide a report to the World Health Assembly through the Executive Board on progress made in the fulfilment of this Resolution;
3. CALLS on donors and development cooperation partners to allocate sufficient resources for health emergency and disaster risk management programmes and partners through international cooperation for development, humanitarian appeals, and support for the World Health Organization's role in all international health related matters.

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

1. Resolution Strengthening national health-emergency and disaster-management capacities and resilience of health systems	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected result:
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.	5.1 Norms and standards developed, capacity built and technical support provided to Member States for the development and strengthening of national emergency preparedness plans and programmes.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The establishment and operation of a disaster risk-management and emergency-preparedness platform, together with a functional safe hospitals programme at national level will help significant progress to be made in the area of disaster risk-reduction, and emergency preparedness, response and recovery in countries at risk. The resolution will further strengthen the all-hazards health-emergency and disaster risk-management programmes as part of national health systems in order to improve health outcomes, reduce mortality and morbidity, protect investment in health infrastructure and strengthen the resilience of the health system and society at large.	
3. Budgetary implications	
(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).	
The figures provided concern the period until the end of 2013.	
At headquarters level	
The total estimated cost is US\$ 7.44 million.	
For the provision of technical assistance (consultancies, including short-term contracts, Agreements for Performance of Work, scientific and technical advisory groups; travel; and training): US\$ 750 000.	

Staff costs (P5 staff for two years, P4 staff for two years and G4 staff for two years): US\$ 1.65 million. This figure is based on the estimated cumulative time to be spent by a number of staff at different levels for this particular activity.

The estimated total cost of strengthening the evidence base for health emergency and disaster risk-management, including operational research and economic assessments: US\$ 2.79 million.

The estimated total cost of supporting national assessments of risks and capacities for health-emergency and disaster risk-management, as a basis for catalysing action and strengthening national health-emergency and disaster risk-management capacities: US\$ 2.25 million.

At regional level

The total estimated cost: US\$ 4.5 million (US\$ 750 000 per regional office).

At country level

The estimated minimum cost of provision of technical support by the Secretariat through the country offices to Member States implementing the resolution: US\$ 250 000 per country.

(b) Estimated cost for the biennium 2010–2011 (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)

At headquarters level

For the provision of technical assistance (including consultancies involving short-term contracts and Agreements for Performance of Work, travel, training, scientific and technical advisory groups): US\$ 250 000.

For the strengthening of collaboration with relevant entities (including public, private and non-governmental bodies and academia) to support country and community health-emergency and disaster risk management, the estimated staff cost is: US\$ 550 000 (P5 staff, US\$ 250 000; P4 staff, US\$ 200 000; and G4 staff, US\$ 100 000). This figure is based on the estimated cumulative time to be spent by a number of staff at different levels for this particular activity for a period of one year.

The estimated total cost of strengthening the evidence base for health emergency and disaster risk-management, including operational research and economic assessments: US\$ 930 000.

The estimated total cost of supporting national assessments of risks and capacities for health emergency and disaster risk management, as a basis for catalysing action and strengthening national health emergency and disaster risk-management capacities: US\$ 750 000.

At regional level

The estimated total cost: US\$ 1.5 million (US\$ 250 000 per regional office).

At country level

The estimated minimum cost of provision by the Secretariat of technical support for implementation through country offices: US\$ 50 000 per country.

(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?

Yes, except at country level.

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

Through fund-raising and voluntary contributions.

5. Administrative implications**(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).**

Implementation will take place mainly in the country offices. Regional offices will provide support for training and capacity building and headquarters will be responsible for interagency coordination, overall planning and development of the evidence-based norms and guidelines necessary to develop and strengthen this area of work. The WHO Mediterranean Centre for Vulnerability Reduction in Tunis will provide technical assistance to all levels in areas of its expertise.

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.

At the headquarters level, staffing is sufficient for the development component of this area and the staff cost is budgeted. At the regional and national levels, there is a need for additional expertise that could be recruited on a temporary basis (short-term contracts and Agreements for Performance of Work).

(c) 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).

Not applicable.

(d) Time frames (indicate broad time frames for implementation of activities).

These activities are planned for the bienniums 2010–2011 and 2012–2013.

As recent experience in Chile had shown, no country was free from the risk of a catastrophic event, and Member States therefore must make appropriate preparations in order to respond adequately and maintain health systems when necessary. Therefore, the draft resolution focused on encouraging the Secretariat and Member States to be proactive in enhancing their capacities to prepare for and cope with health-related management of disasters. Countries should develop national plans to deal with all types of events. Such plans would protect health workers and investments in health facilities, and ensure that health services could be provided at a time of particular need. The draft resolution called for the strengthening of cooperation at the bilateral, regional and global levels so as to build alliances for the exchange of experiences, lessons learnt and best practices with a view to improving responses to disasters. It urged Member States to give priority to the health sector during disasters. It requested the Director-General to ensure that the Secretariat provided the necessary technical support for capacity-building, and elaboration of risk-measurement and risk-management approaches. In that regard she expressed appreciation for PAHO's role in developing national and regional capacity in the Americas. The investment needed was small in comparison to the cost of disasters, and therefore she called on partners to expand their support for capacity-building. She thanked Board members who had already submitted proposed amendments to the draft resolution.

Ms BILLINGS (Canada) welcomed WHO's comprehensive and integrated approach to health system strengthening and commended the progress achieved to date. Canada would continue to support health system strengthening, which was crucial for the attainment of the health-related Millennium Development Goals, and to contribute to donor coordination in the health sector. Canada gave priority to the capability of health systems to improve the health of mothers, infants and children, and was working with partners to support national plans in that area, fill gaps in health systems and expand access to services. Interest in the agenda item under consideration was reflected in the number of draft resolutions before the Board. Canada wished to propose amendments to those draft resolutions, which it would outline in due course.

Dr IBRAHIM (Somalia), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that 2009 had marked the start of action in the Region following the renewed

commitment to primary health care set out in the 2008 Qatar Declaration of Primary Health Care. The Regional Office had prepared a six-year strategic plan (2010–2015) to provide technical support to Member States in promoting primary health care, with four strategic directions: universal coverage, in order to improve health equity; service delivery reform towards people-centred health systems; leadership reform, in order to improve the reliability of authorities; and public policy reform, in order to promote and protect community health. Barriers to universal coverage included limited capacity to raise revenue and make rational use of resources for health; lack of coordination and collaboration between international partners; a growing and unregulated private sector; high rates of out-of-pocket payments; difficulties in reaching the informal sector; and the existence of complex emergencies that hampered long-term planning. For low-income countries, in addition to population-based programmes, a free basic primary health-care package for all financed by government from general revenue and donor contributions was the only viable option at present. For middle-income countries, a comprehensive primary health-care package financed by governments' general revenue, with minimal user fees for some services and medicines to curb over-use, could be made available. For high-income countries the existing government-funded programmes were continuing to provide comprehensive coverage for all citizens and some expatriates. Countries should adhere to principles of equity in moving towards development of compulsory health insurance. The private sector should be regulated in all countries, but should also be regarded as a partner with the potential to improve health system performance. Health investment should be increased through dialogue with ministries of finance and planning and other stakeholders. The measures taken in the move towards universal coverage should be monitored.

Dr DE ASSUNÇÃO OSWALDO SAIDE (Mozambique), speaking on behalf of the Member States of the African Region, said that the Region had made some progress in health system strengthening. The Ougadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium represented the latest and highest level of commitment to achieving better health. The framework for implementation of the Declaration, adopted at the sixtieth session of the Regional Committee for Africa in September 2010,¹ acknowledged the relevance of the nine priority areas highlighted in the Declaration and underscored the need to align national health policies and strategic plans with those priorities. However, many challenges remained, including the need: to shift investment towards comprehensive health system strengthening while maintaining the focus on timely achievement of coverage targets in priority programmes; to institutionalize a government-wide approach to improving the social determinants of health; and to enhance health-service management, especially at district level. Retention of human resources for health was crucial for the attainment of the health-related Millennium Development Goals, and WHO support was needed to strengthen district health systems.

Dr TAKEI (adviser to Dr Omi, Japan) endorsed the view that an increase in domestic financial resources in health systems would help to raise the level of universal coverage. The good health indicators in Japan were due to the nationwide comprehensive health insurance system, which resulted in equitable access to health services. Sustained financing was essential for health system strengthening. Low- and middle-income countries might need to use external financial assistance for some time. However, in the long term, domestic financing was the key to health system strengthening. Every country should start to develop mechanisms for equitable distribution of health finance and for securing health system financing. Delivery of health services to hard-to-reach populations was a core component of universal coverage and vital for the attainment of Millennium Development Goals 4, 5 and 6. Human resources for health were also vital; without an adequate health workforce it was difficult to improve the other five of the six proposed health system building blocks. Japan would

¹ Document AFR/RC60/21.

therefore support vulnerable countries with a view to developing an international agenda for universal coverage that emphasized the importance of human resources for health.

He supported the draft resolutions on health workforce strengthening and on sustainable health financing structures and universal coverage.

Dr DAULAIRE (United States of America) said that the United States Global Health Initiative was committed to improving health-system performance, since efficient and effective health systems contributed to sustained health outcomes, and reinforced economic growth and domestic governance. He supported the call for the alignment of priority setting, operational planning and donor funding. The reports provided a realistic and comprehensive analysis of best practices and challenges in health system strengthening and recognized the diversity of health-care systems across the world. He supported the call for Member States to expand policy dialogue and engage a broader spectrum of stakeholders from within and beyond the health sector. Health systems were fundamental for protecting the health and supporting the rights of marginalized populations, including ethnic and religious minorities, lesbian, gay, bisexual and transgender groups and migrants. Document EB128/8 should have included consideration of the need to develop and improve metrics that tracked progress in health system strengthening and improvements in health outcomes over time; up-to-date information was vital for policy-makers. Health-system policies should be adjusted on the basis of statistical data analysis and performance assessment. Similarly, the Secretariat and Member States should develop and improve metrics for tracking progress towards long-term goals, including the health-related Millennium Development Goals and noncommunicable disease challenges. They should also build their capacity to collect and analyse data in order to monitor and evaluate progress.

He would propose amendments to the draft resolutions in due course.

Dr REN Minghui (China) said that the reports would be useful in guiding Member States, especially developing countries, in health system strengthening. Health system reforms in China were aligned with WHO's recommendations. In 2009, China had established a framework for enhancing reform and was establishing basic urban and rural health systems, with commitment at a high political level and with the necessary financial input. The target, enshrined in the twelfth five-year programme for economic and social development, was to provide all citizens with equitable access to safe, effective and convenient health services. The Secretariat should strengthen its technical guidance to developing countries in health system monitoring and evaluation, including performance assessment. It should continue to provide support for policy dialogue between developing and developed countries, an area in which China was willing to share its experiences.

He supported the draft resolution proposed by Chile on strengthening national health emergency and disaster management capacities and resilience of health systems. China had experienced numerous disasters and accidents in recent years and recognized the need to prepare adequately for rapid response to emergencies. He appealed to the Secretariat and donors to strengthen disaster-response capacity, as it was a vital component of health systems. China was willing to share its experiences in that regard.

Professor STARODUBOV (Russian Federation) endorsed the approach to health system strengthening set out in document EB128/8, which should involve moves to people-centred primary health care and towards universal coverage, with the inclusion of health in all policies. Equitable access to health services was intrinsically linked to health system financing. It was essential to define priorities and to favour primary health care rather than in-patient services. Moreover, activities to prevent communicable and noncommunicable diseases would promote a healthier and more active population and reduce health care costs. He welcomed WHO's progress to date in relation to human resources for health, especially for rural and remote areas, a subject that was of particular importance for the Russian Federation. In the past, the country had succeeded in providing access to health workers through a district approach. It had also been possible to include preventive activities and promote healthy lifestyles and responsible parenthood. The recent modernization programme included a greater emphasis on outpatient care, reforms in legislation on health system access and moves

towards a universal health insurance system across the country. He therefore supported the strategies for health system strengthening set out in the report and proposed that the draft resolution on sustainable health financing structures and universal coverage should be amended to include a reference to the need to develop preventive services, with a particular focus on lifestyle changes.

Ms TOELUPE (alternate to Mrs Gidlow, Samoa) endorsed the strategic and policy direction proposed for health system strengthening on the basis of primary health care. However, further work was needed to facilitate understanding of the six health system building blocks. Integrated programming was needed at all levels, including the global level. She welcomed the suggestions provided in document EB128/8 and agreed on the value of linking policies to operational plans, programmes and political agendas in order to facilitate appropriate resourcing and thus successful implementation. The capabilities of health leaders to link practical translation of the six building blocks to primary health care was a major challenge for health system strengthening. She sought information on how Member States were progressing in the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel. She expressed support for the draft resolutions before the Board.

Professor HAQUE (Bangladesh) expressed appreciation for document EB128/8 and highlighted the issues raised in paragraphs 2 and 3. His country had adopted an intersectoral approach to health policies and programmes since 1998. The Ministry of Health and Family Welfare was particularly grateful for the technical support that the WHO Country Office had provided during the development of the forthcoming five-year national health sector programme.

The movement of health personnel from developing to developed countries was a problem that had yet to be resolved. Bangladesh sought increased support from development partners to train more midwives and nurses.

Dr SEEBA (Germany) commended *The world health report 2010*, which provided a shocking picture of the current global situation: it was deeply concerning that so much of the world's population remained deprived of access to health care and that more than 150 million people faced financial catastrophe largely because of out-of-pocket payments. As the member for the United States of America had commented, health systems needed to protect the health of all people.

Dr BIRINTANYA (Burundi) expressed appreciation for both reports and the draft resolutions that had been proposed. Improving global health required the strengthening of national health systems, particularly at the primary health-care level, in terms of governance, structure and management of available resources, including human resources.

Midwives and nurses were vital to health delivery and particular attention ought to be given to those professions if Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health) were to be achieved. Countries that had actively promoted and improved obstetric services had seen significant reductions in maternal and newborn mortality but further action was needed to ensure that suitably qualified nurses and midwives were available at all levels of health-care systems, particularly given the extent to which developing countries relied on them to help to save lives and maintain well-being.

As the Director-General had stated in December 2010, the capacity of Africa to produce more health-care staff, and retain them, faced many challenges.¹ When health personnel left to work elsewhere, the countries they left behind faced even greater constraints. He therefore called upon Member States to recognize the vital role played by health workers, especially nurses and midwives,

¹ Reforming the education of physicians, nurses and midwives. Opening remarks by Director-General Dr Margaret Chan at the WHO/PEPFAR consultation on transformative scale up of medical, nursing and midwifery education, 14 December 2010.

and to implement the WHO Global Code of Practice on the International Recruitment of Health Personnel. In that context, Kenya and Burundi submitted a draft resolution on strengthening nursing and midwifery, which read as follows:

The Executive Board,
Having considered the reports on health system strengthening,¹

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

The Sixty-fourth World Health Assembly,

PP1 Recognizing the need to build sustainable national health systems and to strengthen national capacities to achieve the goal of reduced health inequities;

PP2 Recognizing the crucial contribution of the nursing and midwifery professions to strengthening health systems, for increasing access to comprehensive health services for the people they serve, and to the efforts to achieve the internationally agreed health-related development goals, including the Millennium Development Goals and those of the World Health Organization's programmes;

PP3 Concerned at the continuing shortage and maldistribution of nurses and midwives in many countries and the impact of this on health care and more widely;

PP4 Acknowledging resolution WHA62.12 on primary health care, including health system strengthening, which called, inter alia, for the renewal and strengthening of primary health care, as well as urging Member States to train and retain adequate numbers of health workers, with appropriate skill mix, including primary care nurses and midwives, in order to redress current shortages of health workers to respond effectively to people's health needs;

PP5 Taking note of the WHO Global Code of Practice on the International Recruitment of Health Personnel;²

PP6 Reaffirming the call for governments and civil society to strengthen capacity to address the urgent need for skilled health workers, particularly midwives, made in the WHO UNFPA UNICEF World Bank Joint Statement on Maternal and Newborn Health;

PP7 Noting the importance of multidisciplinary involvement, including that of nurses and midwives, in high-quality research that grounds health and health systems policy in the best scientific knowledge and evidence, as elaborated in WHO's strategy on research for health, endorsed in resolution WHA63.21;

PP8 Noting that nurses and midwives form the majority of the workforce in many countries' health systems, and recognizing that the provision of knowledge-based and skilled health services maximizes physical, psychological, emotional and social well-being for individuals, families and societies;

PP9 Recognizing the fragmentation of health systems, the shortage of human resources for health and the need to improve collaboration in education and practice and primary health care services;

PP10 Having considered the reports on progress in the implementation of resolution WHA59.27 on strengthening nursing and midwifery;³

PP11 Mindful of previous resolutions to strengthen nursing and midwifery (WHA42.27, WHA45.5, WHA47.9, WHA48.8, WHA49.1, WHA54.12 and WHA59.27)

¹ Documents EB128/8 and EB128/37.

² Adopted in resolution WHA63.16.

³ See documents A61/17 and A63/27.

and the new strategic directions for nursing and midwifery services in place for the years 2011–2015;¹

PP12 Recognizing the need to improve the education of nurses and midwives;

1. URGES Member States to demonstrate their commitment to strengthening nursing and midwifery by:

- (1) developing targets and action plans for nursing and midwifery, as an integral part of national health plans, that are reviewed regularly in order to respond to population-health needs and system priorities as appropriate;
- (2) forging strong, interdisciplinary health teams to address health and health-system priorities recognizing the distinct contribution of nursing and midwifery knowledge and expertise;
- (3) collaborating regionally with the nursing and midwifery professions in the strengthening of national legislation and of regulatory processes that govern those professions, including the development of entry-level competencies for the educational and technical preparation of nurses;
- (4) harnessing the knowledge and expertise of nursing and midwifery researchers to contribute evidence for health-system innovation and effectiveness;
- (5) engaging actively the expertise of nurses and midwives in the development of health and health-system policy and programming;
- (6) implementing strategies for enhancement of inter-professional education and collaborative practice including community health nursing services as part of people-centred care;
- (7) including nurses and midwives in the development and planning of human resources programmes which support incentives for recruitment, retention and strategies for improving workforce issues, such as remuneration, conditions of employment and development of positive work environments;
- (8) implementing the WHO Global Code of Practice on the International Recruitment of Health Personnel especially as it relates to health worker migration, given the national impact of the loss of trained nursing staff;

2. REQUESTS the Director-General:

- (1) to strengthen WHO capacity for development and implementation of effective nursing and midwifery policies programmes;
- (2) to engage actively the knowledge and expertise of the Global Advisory Group on Nursing and Midwifery in key policies and programmes that pertain to health systems, the social determinants of health, health human resources and the Millennium Development Goals;
- (3) to provide technical support and evidence for the development and implementation of policies, strategies and programmes on inter-professional education and collaborative practice and community health nursing services;
- (4) to provide support to Member States in optimizing the contributions of nursing and midwifery to meeting national health policies and the internationally agreed health-related development goals, including those contained in the Millennium Declaration;
- (5) to encourage the involvement of nurses and midwives in the integrated planning of human resources for health, particularly with respect to strategies for maintaining adequate numbers of competent nurses and midwives;

¹ Document WHO/HRH/HPN/10.1.

(6) to keep the World Health Assembly informed of progress made with the implementation of this resolution, and to report, through the Executive Board, to the World Health Assembly in 2012 and 2014.

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

1. Resolution Strengthening nursing and midwifery	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected result:
10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.	10.8 Health-workforce information and knowledge base strengthened, and country capacities for policy analysis, planning, implementation, information-sharing and research built up.
	10.9 Technical support provided to Member States, with a focus on those facing severe health-workforce difficulties in order to improve the production, distribution, skill mix and retention of the health workforce.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
WHO's activities in support of health workforce strengthening have links with strategic objective 10, specifically the two Organization-wide expected results mentioned above. Countries facing severe nursing and midwifery difficulties will be supported through WHO's activities to adopt relevant technical frameworks, tools and guidelines for strengthening nursing and midwifery practice.	
3. Budgetary implications	
(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).	
A total of US\$ 4 million, covering the four-year period 2011–2014, will be required for the implementation of activities at all levels of WHO and the provision of support to Member States.	
(b) Estimated cost for the biennium 2010–2011 (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)	
For the biennium, a total of US\$ 2 million will be incurred (US\$ 500 000 at headquarters level and US\$ 1.5 million at regional level).	
(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?	
A total of US\$ 400 000 is included for headquarters and the regions.	
4. Financial implications	
How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?	
The cost will be met through a combination of voluntary and assessed contributions from Member States, together with contributions from international partners.	
5. Administrative implications	
(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 will be involved; however, implementation will particularly concern countries facing major challenges as a result of critical health workforce shortages.	

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.

No. Additional staff will be required at headquarters and in the regions.

(c) 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).

Exact requirements will depend on the intensity of activities. Every effort will be made to make full use of secondments and the deployment of interns in addition to employing short-term staff.

(d) Time frames (indicate broad time frames for implementation of activities).

The resolution requests the Director-General to report on progress to the Health Assembly in 2012 and 2014. Implementation of activities will be built into biennial workplans for 2010–2011, 2012–2013 and 2014–2015, as appropriate.

Ms TOLSTOI (adviser to Professor Houssin, France) said that achieving the health-related Millennium Development Goals would not be possible unless strong and viable health systems were established. All efforts to that end would also have an immediate impact on how humanitarian emergencies, such as natural disasters, were managed.

Universal access to good-quality and equitable health-care services depended on sustainable financing and she recalled with appreciation the discussions on health system financing at the Ministerial Conference on Health Systems Financing – Key to Universal Coverage (Berlin, November 2010) and the observations in *The world health report 2010*. The Secretariat should work closely with Member States, which were responsible for establishing functioning health-care systems adapted to national contexts and with equitable financing.

User fees could be reduced in several ways, including prepayment mechanisms. The bilateral and multilateral partners gathered within the Providing for Health (P4H) Initiative would also help governments to achieve universal health care coverage.

Another issue was the shortage in health workers; she urged implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel.

Mr BOTELHO BARBOSA (adviser to Dr Buss, Brazil) said that, with the increasing trend in extreme weather events, it was the right time to increase resilience to natural disasters. Brazil had recently suffered extensive landslides, with reports of many dead and missing. Coordinated multisectoral action was the right way to respond to and to prevent similar events in the future. For that reason, he strongly supported the draft resolution on strengthening national health-emergency and disaster-management capacities and resilience of health systems. WHO could contribute greatly in further developing international coordination and national awareness and capacities in emergencies.

His country had instituted a universal health-care system 20 years previously, recognizing that such a system would improve national social and economic development. He shared the views expressed in the draft resolution on strengthening national policy dialogue to build more robust health policies proposed by India, although he would appreciate the opportunity for further consultation on the text.

Echoing other speakers, he welcomed the recommendations emerging from *The world health report 2010* and the fact that the subject of health system strengthening was firmly on the international community's agenda.

Mrs ABBAS (adviser to Dr Said, Syrian Arab Republic) said that she wished to propose amendments to second, sixth and tenth preambular paragraphs and operative paragraph 2 of the draft resolution on sustainable health financing structures and universal coverage. She would submit her changes in writing to the Secretariat.

Dr NARVÁEZ (Ecuador) supported the draft resolution on strengthening national health emergency and disaster management capacities and resilience of health systems proposed by Chile, in

view of the significant social impact of natural disasters and the fact that WHO's role in global health governance allowed for an improved response to such events.

Dr ST JOHN (Barbados) said that health played an integral role in national development and for that reason Barbados had developed its national strategic plan 2002–2012 with a multisectoral approach. A major element of Barbados' ability to anticipate health risks and respond to challenges was its human resources, with the country enjoying one of the highest ratios of health personnel to population among countries of the Caribbean Community. Barbados had taken several measures to improve its health system, including the introduction of legislative measures, the provision of free health care to all citizens at the point of delivery, and novel health-financing mechanisms.

Responding to the adverse effects of seasonal extreme weather events challenged all countries in the region, particularly as their economies relied heavily on tourism. Affected countries needed to be highly resilient. PAHO had played a vital role in disaster preparedness activities and a Safe Hospital Initiative was encouraging governments to invest in structures that withstood extreme weather events and allowed health services to respond more effectively to post-disaster needs.

She supported all five draft resolutions proposed.

Mr YUSOF (Brunei Darussalam) said that, despite the complexities and challenges, it was essential to ensure that health systems resilient and strong, not least so that they contributed to the overall sustainable development of countries. His Government continued to prioritize its health agenda and welcomed the approaches outlined by WHO on improving support to national policy dialogue. The current challenges to health system strengthening required practical solutions and Brunei Darussalam needed continued sharing of best practices.

He supported the five draft resolutions proposed.

Dr TOLEDO ORDOÑEZ (Guatemala)¹ expressed her country's wish to cosponsor the draft resolution proposed by Chile on strengthening national health emergency and disaster management capacities and resilience of health systems.

Ms OSUNDWA (Kenya),¹ said that the draft resolution on strengthening nursing and midwifery had been proposed in the light of current human resource shortfalls with a view to identifying innovative approaches and solutions. Many developing countries still faced great challenges in providing the level of health care necessary to improve health outcomes and achieve the Millennium Development Goals. Appropriately training and retaining health workers would be essential in overcoming those challenges and strengthening capacity. Investing in nurses and midwives would improve several health outcomes including increased vaccination coverage and reduced infant and maternal mortality.

Kenya and Burundi had received proposals for amendments to their draft resolution from other Member States, which they accepted. She supported the other draft resolutions concerning health system strengthening.

Mr SILBERSCHMIDT (Switzerland)¹ welcomed the change in policy, as outlined in the reports, from a service-delivery approach to a universal coverage approach. To ensure health system strengthening, equal efforts would have to be made in the six key areas of health financing, health workforce, health information systems, service delivery, access to medicines, and governance.

He strongly supported the draft resolution proposed by Norway and Japan as a robust health system would rely on a strong health workforce. He would submit some amendments to that text.

He encouraged the Secretariat and Member States to continue supporting initiatives that sought better health-financing mechanisms, such as the Providing for Health (P4H) Initiative.

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

His country was taking several measures to strengthen its own health system, for instance through legislation and a request to WHO and OECD to conduct a review of the system.

Mr ADAM (Israel)¹ expressed support for all five draft resolutions and reiterated his country's satisfaction that the strengthening of public health was being prioritized by WHO.

Referring to the draft resolution on strengthening national health emergency and disaster management capacities and resilience of health systems proposed by Chile, he asked whether the Secretariat had capacity-building programmes on preparedness and adaptation of national systems for disasters such as earthquakes, as it had been difficult to locate any information on the WHO web site. Such information would be invaluable to Israel as it was currently restructuring its adaptation programmes to take earthquakes into account.

Mr CORRALES (Panama)¹ said that health emergencies following recent flooding were a cause for concern in his country and therefore he supported the draft resolution proposed by Chile. In the current reality of climate change, WHO should play a key role in the management of humanitarian emergencies, in collaboration with other relevant actors and entities. Strengthening national capacities required strategic multilateral action.

Mr GOPINATHAN (International Federation of Medical Students Associations), speaking at the invitation of the CHAIRMAN, welcomed the outlined policy directions which should be at the centre of health-worker education. Such education needed to be transformed if greater focus were to be placed on primary health care, and national health plans should include approaches to strengthening health-education institutions, in accordance with the WHO Global Code of Practice on the International Recruitment of Health Personnel. Implementation of the Code would help to overcome many of the current challenges to health-workforce strengthening and the Federation hoped to support countries to that end through consultation on effective health education.

Improving educational infrastructure would help to ensure the training of the necessary number of graduates to cope with the population size and disease burden of countries. Engaging students in community and rural outreach programmes was essential, as it would provide them with a greater understanding of the realities of health-care delivery and the needs of the populations.

Ms BREARLEY (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, welcomed *The world health report 2010* and the Secretariat's reports. Her organization urged Member States to continue prioritizing the issue at the Sixty-fourth World Health Assembly and sought action to support governments in developing health financing mechanisms that provided universal risk protection and guaranteed free access for all at the point of use.

She recalled the recent commitment by the Government of the United Kingdom of Great Britain and Northern Ireland to support low-income countries in moving towards more equitable financing mechanisms and encouraged all Member States that required financial and technical support to respond to the Government's offer with an official request. Other donor countries should also commit further funding and help to increase the capacity of WHO and others to respond to the technical support needs of countries.

Professor NYSSSEN (International Federation for Medical and Biological Engineering), speaking at the invitation of the CHAIRMAN, said that electronic medical records, storage and transmission of medical data, and completion of reports were important elements of health systems of developing countries. WHO had made recommendations on eHealth in the past, but little guidance existed even though software components had an increasing impact on medical techniques and devices. There was a need for better patient record keeping and efficient reporting; the reporting

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

process in many countries did not benefit the patient and consumed resources that could be better used elsewhere.

He urged implementation of appropriate, standardized electronic patient records that would benefit patients, allow monitoring of their health status and facilitate the generation of reports. The Federation recommended the use of high-quality open-source software that would avoid expensive licences in developing countries.

The chronic shortage of suitably qualified information and communication technology personnel in the health sector was also a major challenge. Biomedical or clinical engineers had the relevant training and skills to play a crucial role in the areas of medical devices, medical data acquisition and management, and medical software, which would enable a strengthened system to be established. WHO should therefore provide support to relevant programmes and seek to involve biomedical engineers actively in health system strengthening.

Ms BLANEY (International Council of Nurses), speaking at the invitation of the CHAIRMAN, noted with satisfaction the draft resolution introduced on strengthening nursing and midwifery as strengthening human resources was a tried and tested strategy. Although the current global financial and economic situation presented considerable challenges to health system strengthening, enhancing human resources remained essential to its success. Therefore, her organization wanted nursing and midwifery to continue to be strengthened and the Secretariat and governments to consult with nurses when developing national policies.

Barriers such as inadequate educational investment, outdated regulatory mechanisms and issues of health worker retention and remuneration needed to be removed in the interests of economic and clinical sense.

Ms KEITH (World Vision International), speaking at the invitation of the CHAIRMAN, welcomed the report contained in document EB128/8, particularly the issues raised in paragraphs 1, 2, 4, 5 and 6. However, the Secretariat should encourage more nurses, midwives and communities to be involved in policy dialogue, planning and evaluation, as such participation would improve health worker retention and performance.

She would have liked to see references to resolution WHA58.31 and to equitable health services in document EB128/37, as evidence suggested that services made free at the point of access increased their use by, and improved the health outcomes of, women and children. The Secretariat should increase its support to countries that wanted to move away from user fees towards more equitable mechanisms.

Greater resources needed to be invested in training and national training and retention strategies for health workers in countries with high levels of maternal and child mortality, including the improvement of incentives to encourage health personnel to work in rural areas.

She requested the Board to consider some amendments in the draft resolutions; regarding the draft resolution on sustainable health financing structure and universal coverage, the word “significant” should be removed from the seventh preambular paragraph and the word “basic” in the eighth preambular paragraph should be replaced with “essential”. Concerning the draft resolution on strengthening nursing and midwifery, she asked the Board to include reference to Member States including nurses and midwives in their delegations at the Sixty-fourth World Health Assembly.

Dr ETIENNE (Assistant Director-General) welcomed speakers’ supportive comments; the responses highlighted the importance placed by the global community on strengthening health systems for better health outcomes. She had noted the heavy emphasis on the need to base health system strengthening on the principles of primary health care, equity, solidarity and human rights, and on the need to achieve universal health care and to enhance overall health governance. She had also taken note of the comments made by the member for Samoa on increasing clarity around the building blocks of health systems.

She was gratified by the positive comments on the content of the *The world health report 2010*, in particular the fact that health system financing was a key element for achieving universal health-

care coverage. Many Member States would require technical support from the Secretariat in both financial analysis and implementation of whichever options were chosen by countries. Such action by WHO would only be possible with the support of all partners.

With regard to enhancing human resources for health, she said that the Secretariat was taking action in that regard, not only to increase numbers but also to improve quality and relevance. Work was also being undertaken to develop and implement guidelines on retention.

She strongly supported calls for strengthening national capacity for inclusive policy dialogue; such action would enhance the balance between general disease-specific elements and health systems. In 2010 the Secretariat at all levels had provided support to 32 Member States in order to strengthen that dialogue.

She recognized that the Secretariat needed to take a leading role in raising awareness and encouraging donor support in respect of national health plans. The Secretariat had gained considerable experience through the International Health Partnership and related initiatives (IHP+); as a result several tools and mechanisms had been developed and were being integrated into WHO's work.

The framework for joint assessment of national strategies was proving to be an important mechanism for increasing confidence in national health plans and was also being used by The Global Fund to Fight AIDS, Tuberculosis and Malaria. South–South and North–South cooperation would be essential to the exchange of experiences by countries as referred to by the member for China; such exchanges would require strengthened partnerships and the Secretariat recognized its responsibilities in bringing partners into discussions on that issue.

Regarding metrics, as mentioned by the member for the United States of America, she acknowledged the importance of monitoring progress; the Secretariat had developed core indicators and formulated recommendations on approaches to monitoring health systems progress. Such monitoring needed to be done in the context of multi-institutional initiatives.

She welcomed the draft resolution proposed by Chile and recognized that strengthened national capacity to respond to emergency situations and in enhancing programmes for risk reduction was a vital element of health system strengthening.

She encouraged the member for Israel to contact the European Regional Office directly concerning his question on capacity-building programmes.

She conveyed the Secretariat's recognition of the complexity of the issues involved in health system strengthening and reiterated its commitment to providing support to Member States in building stronger health systems and improving health outcomes.

The CHAIRMAN took it that the Board wished to take note of the reports on health system strengthening contained in documents EB126/8 and EB128/37.

The Board noted the reports.

The CHAIRMAN suggested that Member States should submit all their proposed amendments to the draft resolutions to the Secretariat in writing. Revised versions containing all proposed amendments would then be circulated and discussed by the Board at its ninth meeting.

Ms BILLINGS (Canada) said that she was submitting several proposed amendments that aimed to reflect the jurisdiction of subnational bodies in federated countries such as her own. Chile had already confirmed that it would incorporate such references into its own draft resolution and Canada wished to cosponsor that draft resolution.

She drew attention to the regional office costs associated with the implementation of the draft resolutions; given the pressures already facing countries it might be prudent to meet those financial needs through reallocation of funds or other means rather than by making further requests to donors.

Mr LARSEN (Norway) supported the Chairman's suggestion that all proposed amendments be submitted to the Secretariat in order to facilitate discussion in the Board.

Dr DE ASSUNÇÃO OSWALDO SAÍDE (Mozambique) expressed support for the draft resolutions proposed by Burundi and Kenya and by Chile.

The CHAIRMAN took it that the Board wished to accept his proposal.

It was so agreed.

(For continuation of the discussion, see the summary record of the tenth meeting.)

The meeting rose at 12:30.

SIXTH MEETING

Wednesday, 19 January 2011, at 14:35

Chairman: Dr M. KÖKÉNY (Hungary)

THE FUTURE OF FINANCING FOR WHO: Item 5 of the Agenda (Documents EB128/21 and EB128/INF.DOC./2)

The CHAIRMAN said that the discussion of the item marked the start of a historic process. In 1964, United States Senator J. William Fulbright had referred to the need to dare to think the unthinkable, to explore all the options and possibilities in a complex and rapidly changing world. Those words should guide the Board in its deliberations.

The DIRECTOR-GENERAL, introducing the item, said that since first raised in 2009 and the informal consultation in January 2010, the subject had broadened to include WHO's leadership role in global health and the changes required to take full advantage of that position. She summarized some of the main needs raised over the past year: fundamental change in financing and the way the Organization's resources were managed; evolution of WHO's leadership role in global health governance; response to overextension; and becoming sufficiently agile to respond to new challenges. The financial crisis added to the urgency of finding solutions, although quality of resources was more important than quantity. Reforms were needed through consolidation, division of labour and reducing duplication, both within and outside WHO, with full involvement of Member States, but without changing WHO's Constitution. The Organization had to be crystal clear about its functions and roles, including those areas best left to other bodies.

The areas in which WHO made real and lasting contributions to global health had to be acknowledged before reform was considered: health security; provision of authoritative advice on health development; the formulation and negotiation of global strategies and legal instruments; health system strengthening; knowledge exchange; monitoring of health trends and determinants; and raising awareness about matters overlooked by policy-makers such as neglected tropical diseases and noncommunicable diseases. Shaping the public health agenda on the basis of evidence was central to WHO's work. WHO's core business was underpinned by the values of equity and human rights.

Faced with the significant shortfall in income for the current biennium, she had instituted a major effort to reduce costs and increase efficiency, including merging departments, closing offices and freezing recruitment at headquarters. So far, savings on staff costs were modest but the full impact of the measures should become apparent during 2011 and thereafter.

WHO's deficit was not evenly spread. Room to manoeuvre was limited by high levels of earmarking and small amounts of flexible funding. A team of staff members had been commissioned to identify which programmes in which countries were most likely to face a financial shortfall and need remedial action, taking account of existing resources and capacities. WHO's rapid response to immediate challenges over the past year had highlighted some of the limitations and rigidities of its current financing mechanism and managerial system. The lessons learnt had helped to shape an agenda for reform, comprising six main elements (set out fully in document EB128/21).

The first element was strengthening global health governance. Member States had expressed strong support for increasing WHO's effectiveness as a global health coordinator. Its governance role in the field of development was more problematic, owing to the lack of an effective institutional matrix at the global level to deal with fragmentation and duplication, but countries had emphasized the importance of health system strengthening in that regard. In response to the call for a global forum in

which all the major parties could discuss joint ways to reduce fragmentation and inconsistency, she was proposing a multistakeholder meeting before the First Global Ministerial Conference on Noncommunicable Diseases and Healthy Lifestyles to be held in Moscow on 28 and 29 April 2011. She would report back the outcome to WHO's governing bodies in May 2011 and receive their guidance.

The second item on the agenda for reform was priority setting, which must be done in agreement with Member States and with a degree of flexibility. Due recognition must be given to the Organization's ability to make a difference. In some areas, WHO's role was primarily normative, and should remain; in others, it had to be more active on the ground; and in yet others, WHO's strength was in analysis and advocacy, and action should be left to others. Several partnerships had shown the Organization's strengths but a better division of labour between key stakeholders was necessary. Processes had to respect country leadership and ownership and respond to country needs. Agreement with Member States on priorities for the Secretariat and funding decisions and resource allocation aligned with those priorities would render the issue of earmarked funding much less problematic.

Another element of the reform agenda was planning, budgeting and evaluation. Realistic budgeting would provide incentives for managers to seek efficiency and the budget would serve as a tool for monitoring and accountability. More clarity in terms of results, deliverables, and indicators would encourage Member States to provide flexible funding and would be reflected in the Proposed programme budget 2012–2013. Independent evaluation was important in that context, to shape policy and set priorities.

Central to organizational design – making decentralization an asset and instituting a country-driven process – was the question of the need for a country office in a given country. The focus must be on building capacity for self-reliance and progressing to self-support. There was a growing demand for knowledge and technology transfer, to which WHO would respond positively. Its country offices would be empowered to engage government and other sectors in policy dialogue to facilitate multisectoral action for health.

In terms of human resource policy and practice, the current staffing model was problematic; the difficulties caused by short-term, specified funding were exacerbated by the shortfall in income. Consultations would be needed to find the right model for WHO's human resources that would balance in-house skills and external expertise, specialists and generalists, and the demands of expansion and contraction. Contracts needed a new model, in consultation with staff. Efforts must continue to ensure effective recruitment, performance management and accountability, mobility and competency assessment.

With regard to financing, the objectives were alignment between objectives and resources and ensuring that the Organization's core functions were properly financed, with an increase in the proportion of flexible, predictable financing. With regard to resource mobilization, many Member States objected to receiving different proposals in the same area from several WHO offices: that problem would have to be resolved.

The proposed agenda for reform aimed to elicit guidance from Member States. By the next Health Assembly, Member States would have received a revised and more detailed version of document EB128/21 that would incorporate information on: action on global health governance, a process that would include exploring the potential for agreement on the roles and responsibilities of various organizations and holding a broad-based, inclusive global health forum before the Sixty-fifth World Health Assembly in 2012; a framework for priority setting, linked with the financing of priorities; and a detailed plan for managerial reform in the areas of human resources, organizational design and results-based planning and budgeting.

In February 2011, she would set up a team to begin the process of staff consultation and to conduct the work on managerial reforms. She wanted Member States to be closely involved in discussions on both priority setting and governance, and in March 2011 would convene a small group of experts on global health governance. She aimed to issue a revised document on the future of financing for WHO as early as possible in April 2011.

Dr DAULAIRE (United States of America), noting that document EB128/21 described the core functions recognized by stakeholders as best performed by WHO, said that the Organization should focus on areas where its work was indispensable and it had clear advantages over other institutions. He endorsed the idea of an independent evaluation, perhaps modelled on the recent one for UNAIDS, of WHO's strengths and weaknesses. He asked what impact the new priority setting initiative would have on the Proposed programme budget 2012–2013.

He asked for more information on how WHO's advocacy role was perceived. Advocacy was part of WHO's work in many areas, but alone it might not correspond most effectively to WHO's expertise and might be undertaken better by other global public health players, especially in view of the competing demands for time and resources. WHO's role in development was unclear: it had not traditionally played a major role in that area and the scope of its development activities needed to be refined.

He supported the idea of tailoring WHO's core functions around a set of priorities while emphasizing performance and improving efficiency, but asked how that was to be done, particularly so as to encourage maximum participation from Member States. The statement that requests from Member States for new areas of work could distort the process of responsible priority setting needed to be clarified, although he acknowledged that Member States needed to take WHO's mandate into account when pressing for action on a specific disease or issue.

More details about the proposed forum for Member States, nongovernmental organizations, the private sector and others partners would be welcome. Input from non-State global health actors would be useful, but WHO's governance was first and foremost guided by the Executive Board and the World Health Assembly.

The element of the reform agenda on mobilizing and allocating resources outlined ways to increase the predictability and flexibility of funding, but a paper examining the advantages and disadvantages of those options in relation to current practice would be useful.

Much work would need to be done by all for WHO to continue to safeguard public health, but such work would be an important investment in health security.

Professor STARODUBOV (Russian Federation) welcomed the start of a process his country had advocated during the informal consultation in January 2010, a process that would be evolutionary, not revolutionary; arrangements for consultations on a regular basis, not just during meetings of WHO's governing bodies, should be made. He endorsed the Secretariat's search for ways to rationalize the financing and governance of global health. Such reforms arose from the need to delineate clearly WHO's role and position with respect to other international partners, to define the scope of its activities, and to facilitate flexible responses to new challenges in rapidly changing circumstances. Specific goals, sources of financing and desired results should be clearly laid out, and a more effective system of planning and budgeting designed. There was also a need to have more flexible financing by reducing the proportion of earmarked contributions. That was precisely what the Russian Federation was doing by agreeing that its contributions should be allocated to priority programmes. However, a proposed increase in assessed contributions was not appropriate, in light of the global financial crisis.

He supported the efforts to improve transparency and accountability, enhance leadership and reduce administrative expenditure.

Ms BILLINGS (Canada) expressed appreciation of the reports and the Director-General's leadership on the issue. The results of the consultations thus far should encourage WHO to serve not just as a technical agency, but also as a strategic advisor and catalyst. The tasks of identifying and agreeing a core role, and reorienting the Organization were extraordinarily difficult, involving nothing less than a change of culture.

She supported the ambitious reform agenda, particularly with respect to priority setting, budgeting, human resources and broader stakeholder consultations, but considered that several areas required further attention. Financing, for example, was essential, but, in attracting new donors, caution was needed to ensure that the effort and cost involved was balanced by the benefits gained.

Consideration should be given to how governance could be improved by streamlining the work of the Health Assembly, the Executive Board and the various committees. The Board could do more to help WHO to position itself in the new global health arena involving multiple stakeholders.

She welcomed the stronger focus on country-level effectiveness and concurred that WHO needed to enhance its work as a facilitator, using its strengths as a technical authority and convening power. With its technical know-how, it should help countries to define their own priorities and then encourage partners to adapt to the countries' objectives and capabilities. Functions should be distributed between regions and subregions to best effect.

Dr REN Minghui (China) said that the health agenda had become increasingly important, particularly in the context of social and economic development. It was therefore regrettable that, although WHO had an irreplaceable advantage, its status had gradually diminished. It should not function solely as a technical support agency but should work on consultation, financing and coordination. Global health policy required stakeholders to work together in coordinating global health actions. It was appropriate that WHO should take the initiative in establishing new forums for that purpose, facilitating closer cooperation with civil society and the private sector. Support for and cooperation with Member States in implementing their health strategies should be a priority. Country offices should work not just with the health sector but also with other sectors.

WHO's core business should not be limited to rapid response to public health emergencies: it should also include coordinating the provision of basic health care in natural disaster or conflict situations. WHO should unquestionably be involved in ensuring good governance in the fields of health security and humanitarian actions and in establishing international norms and regulations, where it should take a proactive stance. However, it should move away from development assistance that could be provided by other agencies and instead identify priorities and measures to guide stakeholders. Its two international instruments, the WHO Framework Convention on Tobacco Control and the International Health Regulations (2005), were milestones, but comparable binding instruments were needed in the areas of development and equity in global health. No other organization had more capability for developing such instruments than WHO.

All Member States should strive to increase the proportion of flexible and predictable funding available to WHO. As the Director-General had pointed out, in the crowded landscape of public health, leadership was not mandated – it must be earned.

Mr PRASAD (alternate to Mr Chandramouli, India) said that the ratio of voluntary funds to assessed contributions raised concerns that the achievement of WHO's priorities might be influenced by interests not aligned with its core areas, compromising its ability to respond to countries' health needs. In view of the need for efficient use of funds, country and regional plans needed to be drawn up with care. For example, if his country had developed a web-based health information system, there was no reason for funds to be allocated for that in WHO's programme budget. He asked for the Secretariat's views.

Budgeting needed a realistic planning process. Because the Medium-term strategic plan 2008–2013 had accommodated all activities, the Programme budget had been inflated and prioritization diminished. Flexible funding would be easier once WHO sharpened its objectives. Mechanisms for efficient budget performance must be ensured. The projected closure of WHO offices in countries that did not need them was not, it was to be hoped, related to availability of funds for such countries.

The Secretariat should draw up a sustainable financing plan for submission to the Sixty-fourth World Health Assembly. The plan should aim to secure an independent and expanding leadership role for WHO and reverse the 20%–80% ratio of its finances, with mechanisms to ensure that voluntary and donor contributions were not earmarked but available to promote the overall goals collectively decided by Member States. A code of conduct should be developed for voluntary contributions to prevent a conflict of interest between donors and WHO's priorities. The report stated that Secretariat was set to explore new sources of financing from foundations and the private and commercial sector; the danger was that those funds would come with strings attached.

Mr EL MAKKOU (Morocco) said that he had noted the reported urgency for reform and consequent need to embark on a strategic planning process that would provide flexible funding, harmonize existing resources with strategic objectives, and set clear priorities for the Organization and its partners. Member States must help the Director-General in the steps she was taking to rationalize WHO's activities by providing material and human resources and considering whether, either individually or through their regions, they could perform certain functions, thus lessening the burden on the Organization. As far as priorities and flexibility were concerned, an effort had been made to evaluate WHO's various activities, highlighting the strong and weak points. Specific proposals for reform and strategic changes had to be made. A balance must be struck between rationalization, required to provide the necessary financing, and financing, needed to achieve the greatest number of objectives. The Organization could not use what it did not have. He strongly supported the Director-General's reform efforts and the proposals to continue discussing the matter.

Dr BUSS (Brazil) said that WHO must help to strengthen health systems, not merely health services. As the coordinating agency on international health issues, it must address the social determinants of health. Coherent social and economic policies to overcome inequities and advance development were vital for improving health outcomes. The World Conference on Social Determinants of Health, to be held in Brazil, should help to identify ways of making progress in that area.

WHO should actively seek to harmonize international cooperation and work in a close multisectoral relationship with other organizations and parties, guiding global actions and working to redress public-funding disparities between and within countries. Initiatives should be merged to reduce the existing fragmentation and distortions in global health.

WHO must attract staff members with the most up-to-date skills. The unpredictable nature of the expertise required to implement core functions meant that the Organization needed only a limited number of technical coordinators in addition to a roster of specialized experts to be brought in for short-term consultations.

Discussion of the future of financing must continue in order to ensure a transparent reform process. The Director-General's suggestion to convene a global health forum in 2012 was a step in the right direction.

Dr PÁVA (alternate to Dr Kőkény, Hungary), speaking on behalf of the European Union, said that the candidate countries Croatia, Iceland, The former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, and also Ukraine, the Republic of Moldova, Armenia and Georgia, aligned themselves with her statement. The efforts to make WHO fit for the future had the European Union's full backing. She endorsed WHO's showing increased leadership at the global, regional and country levels through normative and guidance functions and technical support. The time was right for consolidation rather than expansion; hence the importance of WHO's efforts to increase efficiency, effectiveness, accountability and transparency. She supported the reform but was aware that it would entail difficult decisions. She looked forward to the reform being set in motion and to receiving, before the next Health Assembly, a plan with milestones and timelines.

Dr SEEBA (Germany), welcoming the reform process and the Secretariat's courage in critically examining its own work, drew attention to the significant expansion in WHO's budget in recent years, mainly as a result of the marked increase in voluntary contributions. Flexible funding was highly desirable; at the same time, not all donors would or could provide unearmarked contributions, particularly as some were subject to restrictions under national budgetary legislation. A greater problem was the unequal distribution of funds among strategic objectives, which might be rectified by centralizing management of fund-raising under the direct responsibility of the Director-General. Such a system would avoid competition between clusters for available funds and reduce overall fund-raising costs.

He welcomed the focus on results-based planning, budgeting and evaluation. Future budgets must be more realistic with regard to attainable income and results, particularly as no further significant increase in available resources was likely in the near future. Independent evaluation should be explored, and there should be open discussion of which structures within the Organization were necessary to achieve the results expected by Member States while maximizing the return from limited resources. Germany would support the Director-General in pursuing reform.

Dr ALI (alternate to Professor Haque, Bangladesh) said that Member States' expectations of WHO were and should be in tune with the Organization's functions, as laid down in Article 2 of its Constitution. The six core functions set out in the Eleventh General Programme of Work, 2006–2015, which defined how WHO worked to fulfil its mandate, should be included in the reform agenda, taking account of the specific needs, concerns and expectations of Member States. However, the reform plan outlined in the report did not focus sharply enough on some of those core functions.

Any reform agenda should take careful note of the relevance, competence, scope of outreach, and delivery capacity of each level of the Organization, so as to achieve effective synergy between its three levels. Dispensing with or substantially reducing any particular level without taking a closer look at the wider picture was not the solution. He agreed with the Director-General that the process should be bottom-up, inclusive and country-driven. The Organization should become more agile and efficient, but not at the expense of important areas of its activity. The ambitious agenda presented, while still a work in progress, provided a good point of departure for further discussions.

As a specialized agency of the United Nations, WHO could legitimately lead global health governance, exercising its normative function and providing policy guidance and technical support to deal with health crises and emergencies. Such a heavy responsibility required sufficient resources and capacity. Given the importance of global public health for development, WHO should consider setting its own development agenda, placing its work in the proper development context, while at the same time making use of the strengths of other partners and stakeholders. He requested further clarification on the advantages to be gained by creating a new forum to include other actors involved in global health governance.

Dr OMI (Japan) stated that WHO was overstretched. The willingness of the international community to address global health issues was welcome, but a proliferation of initiatives that could not be fully implemented did not help the situation. Member States should keep in mind that effective follow-up and delivery were vital. Furthermore, discussions within the Organization's governing bodies should focus on health issues, in order to counteract the increasing politicization of recent years.

The Organization's human resources should be strengthened, particularly at country level, to ensure the optimum mix of expertise, gender and nationality for maximum efficiency. Enhancing rotation and mobility was one way in which the Secretariat could address that issue. It should also work to eliminate duplication in the roles and functions of the Organization's three levels. He encouraged the Secretariat to pursue a more proactive approach in its work with partner agencies, taking the lead in bringing partners together in a single, coherent direction.

Dr ST JOHN (Barbados) urged WHO to exercise its influence in the international arena on the direction and future of the global economy, convincing decision-makers that health is an integral part of global development. The balance between health needs and economic development lay at the base of decisions about reforms in financing the Organization. Human resources must be adapted, not removed; staff loyalty would be critical in creating a more efficient and effective WHO. The Organization's resource-mobilization strategies would be more successful in attracting flexible funding if donors shared its vision of a new strategic direction, and she therefore supported the proposed multistakeholder forum. The reform timetable should be realistic, allowing as much discussion as possible by countries, regions and partners. In order to overcome the perception that WHO should deliver everything to everyone, Member States should agree on certain priorities that would always receive adequate funding but be subject to regular review.

Dr DE ASSUNÇÃO OSWALDO SAÍDE (Mozambique), speaking on behalf of the Member States of the African Region, highlighted WHO's undeniable and fundamental role as the leader in global health governance. Its leadership was particularly important to the African Region, which bore a heavy disease burden. In order for the Organization to work effectively and provide specialized technical assistance, optimal financial input and rational and strategic use of resources were crucial.

The current financial climate and heavy dependence on earmarked contributions had prevented the funding of certain high-priority activities, with the African Region being particularly affected, and WHO's role should be clarified in order to overcome such uncertainties. Reforms were necessary to ensure that the Organization maintained its leading position in the new financial environment. Its expertise and strengths relative to other international organizations dealing with health issues should be reinforced to make WHO more strategic and selective. It should explore mechanisms for following up financial commitments by international donors. The current debate was a starting point; wider discussions should explore new approaches and opportunities to improve WHO's leadership in priority health areas.

Mr PELLET (adviser to Professor Houssin, France) endorsed the Director-General's overall vision for reform, with a focus on consolidation rather than expansion. WHO should concentrate on its core business of setting standards and facilitating their implementation, which no other organization could do. That role went hand-in-hand with providing information and advice to countries, exercising surveillance, engaging in advocacy, and serving as a moral conscience on health issues, and should be fulfilled at international level and on the ground.

Priorities should be better defined, and should include international health security, epidemiological surveillance, strengthening health systems, and fighting communicable and noncommunicable diseases. They should be set on the basis of need and, in particular, the capacity and added value of the Organization, rather than the availability of budgetary resources.

Field activities required the most reform. The distribution, quality and quantity of staff should be enhanced, thereby contributing to the credibility of the Organization, and measures such as staff rotation were essential in ensuring transparency and skills. Although some delegation was possible in that regard, WHO should remain the point of reference for health matters and should work with all actors present in a country; its coordinating role was vital. Relations between headquarters and regional offices should be reinforced; despite the significant autonomy of those offices, they should not deviate from WHO policy. The Organization should deliver as one.

WHO should reaffirm its position as coordinator and moral authority in global health, particularly in the face of increased influence from other quarters. Credibility and authority stemmed not only from financial resources, but also from competence, expertise, neutrality and transparency, and WHO should assert itself as an authority independent of the private sector, individual states and nongovernmental organizations, which was a difficult but vital task. The Organization should be able to warn states against going too far and to resist demands that it could not meet.

Despite the difficulties involved, the Organization's budget should be more realistic and better planned. If Member States' attention could be drawn to funding imbalances, they could respond accordingly when allocating resources. Successful reform of WHO would depend on commitment from Member States. They should ensure monitoring and follow-up, through the governing bodies; remind other international organizations of the need for mandates to be respected; and avoid politicizing debate. The challenges were significant, but France would support the Director-General in carrying out wide-reaching reform.

Mr LARSEN (Norway), welcoming the reform initiative, said that the increase in the number of parties working for global health could provide opportunities, if the dynamic it created was well-managed through sound governance in the Health Assembly. WHO faced new challenges in fulfilling its role as the global health leader. He expressed support for establishing a forum bringing together a wide range of actors, while stressing that responsibility for WHO governance rested with its governing bodies.

Echoing the report, he emphasized the importance of results-based planning, budgeting and evaluation. Budgeting must be realistic with expected results clearly defined. If WHO were to be the leader in global health, all levels of the Organization must have specific roles, relate to a corporate governance structure, and work towards common priorities and goals. It needed an accountability framework in order to demonstrate to donors that resources were being used optimally and according to priorities agreed by the governing bodies. He endorsed the need for less earmarking, and encouraged other donors to join Norway in increasing the flexibility of their contributions. At the same time, mobilization of resources should also be reformed to avoid internal competition.

Expressing support for the focus on leadership and quality of staff, he highlighted the crucial role of WHO in United Nations country teams and the importance of WHO's commitment to "delivering as one". He also favoured bringing cross-cutting issues such as gender and human rights into the mainstream. Norway would support the reform process and participate actively in it.

Mr LAMBAA (Mongolia) welcomed the dialogue on reform and the proposed agenda. The process should examine the Organization's relative strengths, strengthening and capitalizing on them in order to deliver its key outputs. It was important to avoid duplication within and between the three levels of WHO, each of which should clearly define what it would contribute towards achieving common health outcomes. Financing, planning and budgeting mechanisms should be improved and donor countries should provide more flexible resources. Headquarters funding should be more predictable, while Member States should help to reduce costs and increase efficiency at country level. Reform should address not only the financing but also the role of WHO.

Mrs HANJAM DA COSTA SOARES (Timor-Leste), speaking on the behalf of the Member States of the South-East Asia Region, highlighted the importance of timelines, accountability, transparency and reporting in financial matters, and suggested that increased resources should be allocated to regional and country offices, because they played an important role in putting WHO's programmes into practice and supporting WHO's good governance efforts. The various agencies dealing with global health should coordinate their activities and spending, and Member States should receive assistance in allocating resources. She expressed full support for the Director-General in reforming the Organization.

Ms TOELUPE (Samoa) supported the notion of consolidation rather than expansion, and expressed the hope that WHO's mandated activities would be continued, not compromised. Even though WHO would always remain the global authority in health, monetary needs inevitably had an impact on all priority areas, and WHO should find innovative ways of assuring sustainable and predictable funding. Whatever staffing model was chosen, she urged WHO not to close country offices.

Ms POVEDA (adviser to Dr Narváez, Ecuador) underlined the need to reform the scope of WHO's governance, thereby ensuring more effective policies, in particular regulatory aspects. WHO should move beyond providing advice and strengthen its guiding role in health policy, particularly as the new funding options would place human welfare at its centre. She welcomed the idea of a forum in which Member States could discuss the future financing of the Organization.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland)¹ said that better prioritization in the work of WHO would promote clarity; clarity and coordination between the many organizations currently working on health issues would make the global health system stronger and more effective. Although WHO could not redesign the global health architecture alone, it could reform itself and work with others on a clear division of labour. She welcomed the suggestion for involving

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

major non-State parties in global health. Flexible funding was crucial for the future of WHO's work. Improved prioritization and effective results from the reform process would pave the way for increased flexible voluntary funding. The United Kingdom would support the Director-General in implementing the reform agenda.

Ms SIRISENA (Sri Lanka),¹ welcoming the timely reform process, said that terminology such as "global health governance" and "health security" should be better defined in the context of the role that WHO had played since its creation. The required resources should be made available to allow the Organization to continue to meet health needs in countries. Other entities were fully entitled to assist in health matters, but they should only complement, not replace, the work of WHO, which had a legitimate place within the multilateral system and wide access to populations. WHO's role would be strengthened by an increase in flexible voluntary funding.

In prioritizing programmes, the Organization should respond to the needs of the most vulnerable communities in the developing world, enhancing access to medicine at affordable prices and helping countries to tackle noncommunicable diseases. Support should be provided to developing countries in developing their own research and development capacity, thereby reducing dependence on other countries, and WHO's role in strengthening the primary health care system and the civil protection sector should be enhanced to deal with the impacts of natural disasters and climate change. The needs of every country should be taken into account so that no Member State was left behind.

Further dialogue on reform should precede any specific action. The objective of the process should be to strengthen WHO's role in public health and enhance its leadership in meeting health needs.

Mr SILBERSCHMIDT (Switzerland),¹ welcoming the reform agenda, said that no organization could operate effectively if less than 20% of its financing was stable. WHO must focus on its core functions, ensuring that adequate human and financial resources were allocated to each level of the Organization. The real challenge in priority-setting would be to agree those areas of lesser or no priority. The process of prioritization should be examined and improved and, once agreed on, priorities should remain in place. WHO's mandate as the directing and coordinating authority of global health remained valid but should be reinterpreted. The Organization could not impose coordination on other actors, but should instead serve as a coordinating platform.

In setting priorities, it was essential to analyse topics and functions in conjunction. Discussion of medium- and long-term reform proposals was important, but it should not delay agreement on feasible proposals for reform in the short term. He expressed full support for defining core activities and functions, downsizing some programmes by setting priorities within, rather than between, programmes, establishing a new global health forum, inviting countries to increase their unearmarked core voluntary contributions, and concentrating appropriate technical and negotiation skills into a smaller number of staff at more senior levels. In addition, normative work should be strengthened and the work of governing bodies should be prioritized. Switzerland would support the Director-General in the major reform process just begun.

Ms CREELMAN (Australia)¹ expressed strong support for the Director-General's proposed reform agenda, including the affirmation of WHO's leadership role in normative standard-setting and health security; strengthening its role at country level, through coordination and enhancing the leadership ability and quality of staff; developing a more systematic approach to prioritization and resource mobilization; and strengthening planning, budgeting and evaluation within WHO, including the use of independent evaluation. She urged the Director-General to ensure that the reform process had clear timelines, adequate resources and support from senior staff at all three levels of the Organization. Australia was committed to providing flexible funding that responded to country

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

priorities. While the broader reform process was under way, the Director-General should continue the steps already being taken to improve the focus and efficiency of the Organization.

Mrs NYAGURA (Zimbabwe)¹ said that the performance assessment for the Programme budget 2008–2009 made a compelling case for the need to review the allocation of resources and financing mechanisms, given that some key results under strategic objectives 2 and 4 had been only partially achieved and the Regional Office for Africa had received only about 50% of the approved budgetary funding. WHO should be given the flexibility to align resources in order to respond adequately to needs. Cost-effective mechanisms should be sought to improve the situation. The Director-General should consider using the Independent Expert Oversight Advisory Committee, which could provide advice on internal control and risk management. Consideration should also be given to collaborating with other United Nations entities, drawing on best practices and making use of existing capacity and resources within organizations in the United Nations system. The process should be driven by Member States, in view of the need for them to rethink the manner in which they supported the Organization.

Dr MUKUKA (Zambia)¹ said that any reduction in the human and financial resources of regional and country offices should not compromise their capacity to continue supporting Member States, particularly in high-priority areas such as HIV/AIDS, malaria, tuberculosis and maternal and child health. The concept of a model allowing for expansion and shrinkage of country offices according to need required careful thought and consideration.

Dr SIRIWAT TIPTARADOL (Thailand)¹ frankly identified major problems facing the Organization: incompetent staff, particularly in regional and country offices; limitations on financial resources that threatened to distort WHO's and national priorities; and the proliferation of bodies and initiatives in global health. WHO needed comprehensive reform, focusing on human resources and leadership besides financing. Adequate human and financial resources must be available to maintain its key functions: ensuring health security, setting norms and standards and issuing guidance, providing evidence for health system development, promulgating health information for priority-setting and policy-making, and convening meetings. Reform should aim to improve efficiency, recruit and retain competent staff, harmonize and streamline actions, using its influence to obtain financial commitments. The recruitment, assessment and retraining processes should be reformed to ensure that competent staff were deployed at all levels, particularly in regional and country offices in order to capitalize on WHO's convening role and increase its outreach capacity; the skill mixes for regional office staff and WHO Representatives should be enhanced. The structure of the Organization should be re-examined, with particular attention given to the value of regional offices: were they an expensive bottleneck and unnecessary layer of bureaucracy?

The global financial crisis provided an opportunity to streamline the Organization and improve its efficiency. The chronic reliance on extrabudgetary, mostly earmarked, resources, which could distort priorities both within WHO and at country level, should be resolved, and innovative funding options should be pursued. He welcomed moves to strengthen country-driven approaches to policy, strategy and planning, with a view to harmonizing the work of the many donors and actors in the global health field. WHO should re-establish its reputation as a source of information and advice, and exploit its convening powers. Consideration should be given to making use of external evaluation.

In terms of global health governance, WHO should strengthen countries' capacity to harmonize and coordinate donor programmes in line with their national strategies, set measurable targets for progress in national institutional capacity to ensure aid effectiveness, as set out in the Paris Declaration on Aid Effectiveness (2005), and work with development partners and global health institutions to achieve that goal. With regard to priority-setting, WHO should enhance Member States' capability to set their own health priorities and prepare their own national strategies and plans. Priority-setting was

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always hampered by the limitations of data. He commended WHO for taking serious action to produce global recommendations on the use of evidence.

The meeting rose at 17:30.

SEVENTH MEETING

Thursday, 20 January 2011, at 09:05

Chairman: Dr M. KÖKÉNY (Hungary)

1. THE FUTURE OF FINANCING FOR WHO: Item 5 of the Agenda (Documents EB128/21 and EB128/INF.DOC./2) (continued)

Ms KEITH (World Vision International), speaking at the invitation of the CHAIRMAN, said that, in May 2010, a survey conducted the previous year had identified five ways for WHO to assume its leadership role in global health governance: expanding the role of the International Health Partnership and related initiatives (IHP+); establishing a global health governance council; using a legally-based framework convention for global health; establishing a Committee C as a subsidiary body of the World Health Assembly; and strengthening WHO's role and capacity to coordinate international health governance issues. The research had shown that WHO's leadership in coordinating a harmonized approach to health issues was essential, but depended on Member States' support. Furthermore, internal reform of WHO's systems and staffing profiles was urgently required. A new forum for dialogue, led by WHO, should be convened and should contribute to the decision-making processes of the Health Assembly.

Given the high proportion of earmarked funding for WHO, a mechanism should be devised to ensure that adequate resources were allocated to normative work, particularly in maternal and child health, strengthening of health systems, policy dialogue, global health governance, and coordination related to development. To increase transparency in the prioritization process, a set of criteria should be established by the Health Assembly. She welcomed the proposed changes in organizational design, the pledge that WHO would work more closely with civil society organizations at country level, and the proposed reforms of WHO's human resource policy. The Director-General should consider employing at all levels more nurses and midwives, as well as policy specialists. Her organization would present an updated report to the Health Assembly in May 2011.

Mr LEGGE (CMC – Churches Action for Health), speaking at the invitation of the CHAIRMAN and also on behalf of the People's Health Movement, said that the financial crisis facing WHO was distorting priorities. The allocation of funding for work on the social determinants of health had decreased, while expenditure on activities related to medicines was growing even though funding to promote the rational use of medicines had dried up almost entirely. Member States ought to increase their contributions. There must be a clear code of conduct on voluntary contributions and donations in order to prevent conflicts of interest between donors' priorities and WHO's agenda, which should be driven by the interests of Member States. WHO's constitutional responsibility to lead in international decision-making on health issues meant holding donors to account: WHO must engage in the politics of health as well as giving technical advice.

Mainstreaming of cross-cutting issues might lead to their neglect because they had no champion inside the Organization. A strong focus on gender was essential for reducing the global burden of disease, which was rooted in gender inequality and patriarchy. The poor people of the world urgently needed a courageous, independent and properly funded Organization. The Board should urge Member States to increase their level of un-earmarked contributions.

Dr RASAE (Yemen) said that WHO should make the most of its advantages. It was accustomed to employing consultants, for example: it would probably need to continue doing so, but it could

perhaps employ them at national or regional level rather than in headquarters in order to cut costs. WHO would need to find alternative sources of financing, which could be facilitated by fund-raising visits by the Director-General. In addition, the Organization could launch fund-raising appeals, as other organizations, such as UNICEF, had already done.

The DIRECTOR-GENERAL thanked members for their encouraging remarks, which reaffirmed their belief in WHO and its leading role in world health. Members had expressed their eagerness for the reform process to begin. In some areas, she could take action immediately under the authority vested in her by Member States, whereas in others she would need to consult the Health Assembly. She was thus planning immediate, medium-term and long-term measures. Her main concern was to run the Organization in the way Member States wanted. She had been encouraged by the willingness of many Member States to share the responsibility for the reform process, rather than leaving it to the Secretariat alone.

The Proposed programme budget 2012–2013 had been discussed by the regional committees and, in the previous week, by the Programme, Budget and Administration Committee. Member States' priorities had emerged clearly: they included the strengthening of health systems; achieving the Millennium Development Goals; disease control through the application of the International Health Regulations (2005); WHO's role in the humanitarian sector; and activities to combat noncommunicable diseases. The Secretariat would endeavour to align the available resources with those expressed priorities. She had promised that Committee that she would issue a revised version of the Proposed programme budget 2012–2013 six to eight weeks before the Sixty-fourth World Health Assembly. All interested stakeholders would be consulted. Some changes on which there was consensus could be made straight away, including simplification of the strategic objectives and improvement in process and results indicators. The more far-reaching changes that members had called for, which amounted to an entirely new approach to results-based strategic planning, would have to wait until planning for the next cycle, 2014–2015. She would provide more details to the Health Assembly.

She pointed out that consultations with stakeholders, such as the proposed new forum scheduled to meet for the first time in Moscow in April 2011, were not a new phenomenon for WHO, although there was no formalized structure for them. For instance, WHO had supported regional and country-level consultations involving civil society organizations and industry representatives as part of the preparations for the forthcoming high-level meeting of the United Nations General Assembly on noncommunicable diseases. Member States had indicated their desire to see a more formal mechanism involving all interested stakeholders. However, the Secretariat needed to identify the best way to channel feedback from such a mechanism to WHO's governing bodies. The Secretariat would seek the advice of a group of experts, use the forthcoming forum meeting in Moscow to investigate the best feedback method, and present its proposals for the new forum to the Health Assembly in May 2010. The formal mechanism could potentially begin operations in May 2012.

Recent discussions with Member States, including those in the Programme, Budget and Administration Committee and the current session of the Board, had painted a clear picture of their collective vision that was still based on WHO's Constitution but involved elements of change. The first thing Member States wanted was coherence in global health, with WHO taking the lead and enabling the many different parties to play active and effective roles in contributing to the health of all people, fulfilling WHO's primary function as the directing and coordinating authority on international health work. The second was an Organization that met the expectations of its Member States, working on agreed global health priorities, focusing on the actions and areas where it had a unique function or strength compared to other organizations, and financed in a way that facilitated work under that focus, without mandate creep. The third was an Organization that was fit for purpose: efficient, responsive, neutral, transparent and accountable.

She planned to submit to the Health Assembly in May 2011 a programme of reforms designed to put that collective vision into operation. The reforms would include a plan for strengthening WHO's central role in global health governance, including proposals for regular multi-stakeholder meetings beginning in 2012 (subject to the reaction of the Health Assembly in May 2011) and means of tackling

other aspects of global health governance such as possibly a framework for engagement in global health, sharing of best practices, and optimum division of labour. Clear rules of engagement should result in a much more coherent and synergistic approach to achieving the priorities agreed by Member States. The reforms would clearly define WHO's unique role and function, supported by a framework for systematic and objective priority-setting, with a financing model that would ensure that core functions were adequately funded. She would be engaged personally in the consultations on that issue.

A detailed plan for managerial reform would be drawn up, including a new results-based planning framework incorporating the current Programme budget, Medium-term strategic plan 2008–2013 and Eleventh General Programme of Work 2006–2015, with a plan for their implementation that would cover the preparation of the Proposed programme budget 2014–2015, ensure greater precision of the expected results and indicators, and create a mechanism for independent evaluation. The human resources strategy would be revised to facilitate the recruitment of high-quality, competent and experienced staff. She would propose revisions to the Staff Regulations and Staff Rules that would bring that strategy into line with the Organization's new business model. She would consult with staff, without whose engagement it would be difficult to accomplish any reform quickly. Moreover, she could not ride roughshod over the acquired rights of current staff, although different conditions could be applied to staff employed in the future. Some changes, however, could be made already that would help to meet Member States' expressed desire for greater staff mobility, objective performance management and a robust mechanism for responsibility and accountability of staff.

Managerial reform would include proposals for organizational design that would include a clear division of labour between the three levels of the Organization and a plan to align staffing and resources with those functions, as well as a corporate approach to resource mobilization. She would also provide more clarification on the mainstreaming of cross-cutting mandates such as gender, health promotion, human rights, primary health care and social determinants of health, and on how those fundamental priorities would be monitored and measured so as to ensure that no programme disregarded them.

A document summarizing her proposals would be distributed later in the session and the information would then be presented in a formal submission to the Health Assembly in May 2011.¹ She thanked members for the confidence they had placed in her.

The Board took note of the report.

2. PROGRAMME AND BUDGET MATTERS: Item 6 of the Agenda

Programme budget 2008–2009: performance assessment: Item 6.1 of the Agenda (Documents EB128/3 and EB128/22)

Dr MOHAMED (Oman), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, reported briefly on the Committee's comments on the performance assessment as set forth in document EB128/3. In particular, the Committee had sought clarification of the concept of partial achievement of a strategic objective and suggested external validation of the exercise. The Committee had recommended that the Board note the report contained in document EB128/22.

Mr PRASAD (India) noted that 39 out of the 81 organization-wide expected results had been rated as "partly achieved", including three out of six results relating to strategic objective 2 and five out of eight results relating to strategic objective 4, both of which strategic objectives were directly

¹ Document EB128/INF.DOC./3.

related to Millennium Development Goals 5 and 6. In addition, half the 12 results under strategic objective 10 had been only partly achieved, including vital areas such as health information systems, evidence-based health decision-making, national health systems research, fund-raising, evidence-based policy and technical support for Member States. Those crucial gaps in health systems strengthening might have contributed to the underachievement of strategic objectives 2 and 4. Strategic objectives 3, 4, 7 and 9 had attracted insufficient voluntary funding. He asked the Secretariat for a more detailed explanation.

Dr JAMA (Assistant Director-General) noted that performance had been subject to strict internal peer review, with extensive discussions between the regional offices and headquarters. A strategic objective had been classified as “partly achieved” if just one indicated target had not been met at headquarters or in any one of the regions, even though sometimes a strategic objective had been achieved at the global level. As requested by Member States, the Secretariat would present a more detailed analysis in the performance report related to the Programme budget 2010–2011.

The shortfall in funding for strategic objectives 3, 4, 7 and 9 certainly was cause for concern. Those areas did not attract large amounts of voluntary funding, even though they dealt with important issues. In addition, the implementation rate was not always optimum: only 53% of the approved budget for strategic objective 4 had been spent, for example. Underspending might have been due to shortcomings in implementation, delays in the receipt of voluntary funding, or the need to carry over funds to the following biennium in order to cover commitments such as staff salaries and approved activities. It was to be hoped that sufficient voluntary funding would be forthcoming in the current biennium to cover the objectives in question, particularly since the Director-General had singled out some of them as particular priorities.

The Board took note of the report.

Implementation of Programme budget 2010–2011: update: Item 6.2 of the Agenda (Documents EB128/3 and EB128/23)

Dr MOHAMED (Oman), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, summarized the Committee’s deliberations on the item as reported in paragraphs 10 to 13 of document EB128/3. The Committee had urged the Secretariat to take the projected shortfall in income for the current biennium into account in revising the Proposed programme budget 2012–2013. It had recommended that the Board note the report.

Ms BLACKWOOD (alternate to Dr Daulaire, United States of America) welcomed the information about the steps being taken to reduce funding imbalances among the strategic objectives and major WHO offices, and commended efforts to contain costs through actions related to human resources and other measures. She asked for more details about the effects of the post occupancy charge introduced in January 2010.

Mr LARSEN (Norway) noted the serious financial situation and the information given to the Programme, Budget and Administration Committee to the effect that the Programme budget 2010–2011 showed a shortfall of US\$ 320 million as at January 2011 because of decreased voluntary contributions and the lack of flexible funding. He asked for more details of the priority list for implementation of the current Programme budget, which had been drawn up by the Global Policy Group; in particular, what criteria had been used in the exercise, and which strategic objectives were most likely to be scaled down or abandoned? His country attached particular importance to the strategic objectives related to the Millennium Development Goals, health systems and noncommunicable diseases, which the Director-General had also identified as priorities.

It was the collective responsibility of Member States not only to guide the Director-General in managing WHO, but to enable her to do so effectively. The constraints imposed by the lack of flexible funding were clear. He called upon Member States to consider contributing or increasing their

contributions to the core voluntary contributions account, and to make those contributions flexible. His Government awaited a prompt reply to the letter it had sent to the Secretariat in December 2010.

Dr SEEBA (Germany) expressed deep concern at WHO's financial situation. Only 17 months after the approval of the Programme budget 2010–2011, the Organization faced a possible shortfall of up to US\$ 600 million. The projected income for the current biennium might amount to only US\$ 3300 million, which was US\$ 1200 million less than expected 18 months earlier. He asked for more details about the programmes that faced significant shortfalls, those that might need to be abandoned completely and the basis on which the decision would be made. It was essential to ensure that the problem did not recur. He asked for information about the current status and predicted future evolution of the carry-forward funds.

Dr MOHAMED (Oman), welcoming the willingness expressed by some Member States to provide more flexible financing, said that it still seemed likely that some programmes would have to be drastically cut or abandoned. The staff members of those programmes could be transferred to other programmes, but it was important to recognize that in such cases they might not be making the best use of their expertise. Activities could not simply be mothballed in one biennium and re-launched in the next; they required an assured financial base. It might be possible to avoid eliminating programmes by reducing the number of field visits by WHO experts or by ensuring that any field visit benefited an entire region rather than an individual country.

Dr JAMA (Assistant Director-General) said that the Secretariat was confronting the shortfall in, and inflexibility of, income and was working to raise more voluntary funding over the remaining 11 months of the biennium. It was also analysing the funding shortages and the imbalances between strategic objectives and WHO offices, and would report more fully on those matters to the Sixty-fourth World Health Assembly. The criteria for identifying the strategic objectives that were most vulnerable to cuts were being worked out as part of the mid-term evaluation of the Programme budget 2010–2011. The Secretariat had covered the current deficit of US\$ 320 million by using income from the carry-forward facility, which had amounted to US\$ 1500 million. However, as most of that funding was earmarked for specific programmes, the Director-General could not reallocate it at will. Given the current financial situation, the normal level of carry-forward, which was sufficient to cover roughly six months of activities and staff costs and amounted to about 25% of the total budget, might not be available at the start of the next financial period.

The post occupancy charge, which was equivalent to about 5% of staff salary costs, had generated some US\$ 140 million to date. That sum was sufficient to finance United Nations common system security charges and staff development and learning costs, and had eased the financial constraints on strategic objectives 12 and 13. However, there were some fears that it might increase total staff costs.

The Board took note of the report.

Medium-term strategic plan 2008–2013 and Proposed programme budget 2012–2013: Item 6.3 of the Agenda (Documents EB128/3 and EB128/24)

Dr MOHAMED (Oman), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that the Committee had welcomed the Secretariat's willingness to take into account the current financial situation when revising the Proposed programme budget, but had stressed the importance of preserving certain priorities, particularly noncommunicable diseases and activities related to the achievement of Millennium Development Goals 4 and 5. It had asked for any revised budget documents to be submitted six to eight weeks before the Sixty-fourth World Health Assembly in order to allow time for review and discussion, and had stressed that the budget discussion must be closely related to the discussion on the future of financing for WHO. The Committee had recommended that, in its recommendations concerning the draft Medium-term strategic plan 2008–2013

and the Proposed programme budget 2012–2013, the Board should take into account the Committee's comments as set forth in paragraphs 14 to 20 of document EB128/3.

The CHAIRMAN confirmed that the Proposed programme budget 2012–2013, contained in document EB128/24, would be thoroughly revised in the light of the current financial situation and the Board's discussions on the future of financing for WHO and then resubmitted to Member States.

Dr OULD HORMA (Mauritania), speaking on behalf of the Member States of the African Region, noted with satisfaction that topics fundamental to the Region, including maternal and child health, communicable and noncommunicable diseases and the achievement of the Millennium Development Goals, had been given due attention in the Medium-term strategic plan. He commended the efforts of WHO and donor countries to maintain an acceptable overall level of financing in an unfavourable environment. Nevertheless, he was concerned at the reduction in the budget allocated to strategic objective 2 in recent years, which was already affecting WHO's capacity to provide needed technical support for activities to combat HIV/AIDS, tuberculosis and malaria. He urged partners and donor countries to ensure that WHO could continue to carry out its vital role in that area. He also called for a guarantee of resources for maternal health, noncommunicable diseases and strengthening of health systems.

Ms BILLINGS (Canada) said that the discussions in the Programme, Budget and Administration Committee and during the current session of the Board had underlined the importance of the Director-General's plan for the future of financing for WHO. She expressed concern about the low overall implementation rates and underscored the need for future budget reports to identify the factors affecting those rates. The carry-forward facility was an important tool, but the Secretariat should clearly justify the amounts it wished to carry forward.

Mrs HANJAM DA COSTA SOARES (Timor-Leste), speaking on behalf of the Member States of the South-East Asia Region, thanked the Secretariat for the technical and financial cooperation it had provided in the Region, but stressed that many countries were making insufficient progress towards achievement of the health-related Millennium Development Goals and therefore required increased support. Her country needed strong support for health system strengthening, human resources development and the achievement of the Millennium Development Goals. Given that the current overall level of the Proposed programme budget 2012–2013 was close to that of the approved budget for 2010–2011, there should be opportunities for increased budget allocations when the budget was revised.

Dr PÁVA (alternate to Dr Kökény, Hungary), speaking on behalf of the European Union, welcomed the Secretariat's plan to revise the Proposed programme budget in the light of the current economic situation and the concerns of Member States. Further information was needed on the financial implications of the resolutions adopted by the Board at the current session, which amounted to more than US\$ 25 million, a figure that was not contained in the current draft of the Proposed programme budget 2012–2013. How would that funding be secured? That situation illustrated the gap between policy and financial decision-making that was at the core of the debate on the future of financing for WHO.

With regard to the report of the Programme, Budget and Administration Committee, she encouraged the Secretariat, in order to ensure complete transparency, to be more explicit about the criteria that would be applied in making changes to the priorities and budget cuts. In addition, she requested further information on the budget revision process that would take place between the current session of the Board and the Sixty-fourth World Health Assembly in May 2011. The revised Proposed programme budget 2012–2013 should ensure that recent public health gains were not jeopardized, include a clear explanation of the differences between it and the programme budget proposal contained in document EB128/24, lay out a clear results chain showing outcomes and impact, and establish clear criteria for a more balanced distribution of resources between regions and headquarters. She sought

assurances that activities relating to Millennium Development Goals 4 and 5, noncommunicable disease and health system strengthening would continue to be supported or scaled up. The revised proposed budget should reflect WHO's real implementation capacity and identify areas where efficiency could be improved.

Dr OMI (Japan) said that, in the light of the current global economic situation, he was pleased to note that the Secretariat had requested zero nominal growth in the draft Proposed programme budget 2012–2013. In recent years, WHO had received extremely high levels of voluntary contributions, and greater visibility should be given to those contributions in order to encourage other possible donors. Further information was needed on the cost–effectiveness of the partnerships and collaborative arrangements shown in Appendix 2 of document EB128/24. The differences between the successful fund-raising methods of the Global Fund to Fight AIDS, Tuberculosis and Malaria and WHO's approaches should be analysed. He would also like additional information on the more systematic and coordinated approach to resource mobilization to which the Director-General had referred in her remarks on the future of financing for WHO.

Ms BLACKWOOD (alternate to Dr Daulaire, United States of America) said that, in the light of the latest projections for the current biennium, financing streams required careful consideration in the revised Proposed programme budget 2012–2013. Interventions that had proved their relevance and effectiveness, particularly those relating to maternal and child health, noncommunicable diseases and achievement of the Millennium Development Goals, should be given high priority. She noted the new approaches to cost recovery from activities funded from voluntary contributions and that the dialogue on the future of financing for WHO had highlighted the large proportion of voluntary funding, the management implications of that situation, and the pressing need for sustained and flexible funding.

Dr SEEBA (Germany) said that the report on implementation of Programme budget 2010–2011 would provide an excellent basis for the revision of the Proposed programme budget 2012–2013. Future budgets should be as realistic as possible, and, although they might retain a degree of aspiration, they should be based on sound assumptions.

Mr LARSEN (Norway) agreed that the revised Proposed programme budget should be as realistic as possible and reflect the current financial situation of the Organization. At the same time, the focus on the strategic objectives relating to the health-related Millennium Development Goals, noncommunicable diseases and health system strengthening should be maintained and, if possible, sharpened. He shared the concern about erosion of the carry-forward funds; the more realistic revised budget proposal should make it possible to maintain those funds at a sufficient level to ensure continuity of operations. He requested clarification of how, exactly, the financial and administrative implications of resolutions proposed for adoption by the governing bodies were accounted for in the existing budgetary framework.

Mr PRASAD (adviser to Mr Chandramouli, India) requested the Secretariat to take into consideration the needs of Member States of the South-East Asia Region when revising the Proposed programme budget 2010–2013. That revision must also take into account the financial requirements for activities relating to the Millennium Development Goals and noncommunicable diseases under strategic objectives 3 and 4.

Dr RASAE (Yemen), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that, in order to ensure a realistic budget, more accurate baselines were needed. The relationship between the strategic objectives and overlapping areas should be clearly delineated in the revised Proposed programme budget and more information should be provided on the cost of sustaining WHO's core functions within the strategic objectives. The revised proposed budget should be linked to the agenda of reform, and the distribution of work between WHO and its partners should be made clear. Staff members were the Organization's most important asset, and efforts should be

made to maintain core staff in priority areas, with the emphasis on quality rather than quantity. There should be more flexibility in financing for priority areas, and the proportion of un-earmarked funds should be increased.

Dr AL BITTAR (adviser to Dr Said, Syrian Arab Republic) said that the importance of programmes to individual countries should be taken into account during the budget revision process. Investment in programmes on noncommunicable diseases would be one of the best uses of the Organization's resources.

Mrs NYAGURA (Zimbabwe),¹ acknowledging the need to streamline the budget, appealed to the Director-General to ensure that due consideration was given in the allocation of resources to the situation of the African Region, particularly with regard to strategic objectives 2 and 4. She was confident that the Director-General remained committed to improving health in the African Region; however, the Director-General could only do so much. Member States had to assist the Director-General in safeguarding the gains made in priority areas and should allow her more flexibility in allocating resources. The Secretariat should investigate new sources of funding, but the Director-General had to be given a clear mandate to do so.

Dr JAMA (Assistant Director-General) acknowledged the comments on the need for a realistic budget. The Proposed programme budget 2012–2013 had been drafted after consultation with Member States and document EB128/24 set out the priorities identified. The Organization, namely Member States and the Secretariat, had committed itself to achieving certain expected results but, on current income projections, it appeared likely that some of the targets approved by the Health Assembly for the biennium 2010–2011 would not be achieved. The more realistic Proposed programme budget to be presented to the Health Assembly in May would have to be supported by a similarly realistic funding mechanism. Although the proposed budget did not call for any increase in assessed contributions, he appealed to Member States to give serious consideration to that issue, bearing in mind the impact of cost increases, currency fluctuations and the global financial situation on the Organization's ability to carry out its work. The erosion of carry-forward funds, which represented an essential source of funding, was a serious concern, and the Secretariat required advice from Member States on the matter. As to the financial implications of resolutions, the Secretariat incorporated the decisions of the governing bodies into its yearly planning. It was, however, sometimes difficult to accommodate resolutions adopted during a biennium under the Programme budget approved by Member States for that financial period. Advice was also needed from Member States on how to raise the funds required to give effect to the policy decisions they adopted in order thus to avoid the disconnect between priorities and funding. He had taken note of members' emphasis on the need to safeguard recent public health gains; the Secretariat would strive, through prioritization, to do so. It would also work to improve assessment and reporting on the achievement of expected results.

In response to the concerns expressed regarding funding for strategic objective 2, he noted that, even though the Organization had experienced a decline in income for activities relating to HIV/AIDS, work in that area had increased as a result of collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria and other multilateral organizations. Such partnerships made a welcome contribution to the Organization's work, but the Secretariat had little control over the nature and extent of those contributions because each partner had its own governance mechanisms.

With regard to resource mobilization, there were evidently deficiencies in the current fund-raising mechanism. It was often difficult to align the funding received with the established priorities. The new corporate approach would aim for synergy and coordination. Predictable, flexible financing was the best way to ensure that the Secretariat was accountable to Member States. The programme budget was developed on the basis of both the global public health needs identified by Member States

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

and the costs of meeting those needs. The Secretariat would begin consultations with Member States immediately and aimed to have a revised Proposed programme budget 2012–2013 ready by 31 March 2011.

The DIRECTOR-GENERAL acknowledged that policy and financing had become disconnected; that owed largely to earmarking of voluntary contributions, which was indeed a prerogative of donors but made it difficult to reallocate funds as needed. Another reason was the establishment of intergovernmental negotiating groups, which, although useful, consumed large amounts of financial resources that could be used to fill funding gaps. She had heard the appeals from two regions to bear in mind their special needs when allocating limited resources, but she could not simply take funds away from one region and give them to another, particularly as funds allocated to regions were often also earmarked. More resources could be freed up for use at the country level, however, if, for example, the Secretariat was not asked to organize so many meetings or produce so many documents and strategies. At the same time, she recognized that the Secretariat sometimes did not make the most efficient use of resources, such as when it failed to deliver promised results in a timely manner, necessitating no-cost extensions. She was working to rectify that failing.

With regard to resource mobilization, she appealed to Member States to authorize her to explore possible sources of funding from the private sector. She acknowledged the concerns of some Member States with regard to collaboration with the private sector, but stressed that any collaboration would include safeguards for WHO's independence and immunity from the commercial interests of private industry. She welcomed the suggestion that WHO could learn from the resource-mobilization strategies of other bodies, for example through work to raise funds at the country level. She could not guarantee that she would not ask for an increase in assessed contributions in the next biennium, but an increase might not be necessary if Member States were willing to provide more flexible funding.

Dr BUSS (Brazil) expressed concern at the Director-General's request to Member States to allow her to instigate discussions on funding with the private sector. The Organization must be protected from the commercial interests of the private sector. WHO was an intergovernmental organization and it must be supported by its Members' governments. Member States chose how to invest their money, and, rather than bailing out the banks and financial institutions that bore the responsibility for the global financial crisis, they should invest in health and the work of WHO.

Dr OMI (Japan) said that it would be ideal if all donor countries were able to provide funds that were entirely un-earmarked but that was often not possible for political or financial reasons. Earmarking of funds was not necessarily a problem, provided that certain conditions were met: first and foremost, all voluntary contributions should be in line with WHO's priorities. A regular briefing session should be held for all donors in order to make them aware of the Organization's priorities and areas in which there were shortfalls.

Mr LARSEN (Norway) requested the Secretariat to suggest a possible structural approach that would enable it to implement resolutions adopted by the governing bodies with the level of funding approved by Member States for a given biennium, bearing in mind that it would not always be possible to raise additional funds for that purpose.

Dr RASAE (Yemen), noting that he was a member of the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria, pointed out that it had a different relationship with donors and a different approach to resource mobilization overall than WHO did. Its philosophy regarding collaboration with the private sector also differed. The wealthier donor countries should take a more sympathetic view towards the Organization and its financing, and he considered that the suggestions put forward by the member for Japan were worth exploring.

The DIRECTOR-GENERAL stressed that she would not commit WHO to collaborating with the private sector without the approval of Member States, nor would she take any other steps that

might jeopardize the independence and integrity of the Organization. Responding to the member for Norway, she clarified that she had not meant to imply that the Secretariat would necessarily seek additional funding in order to implement resolutions. The problem was that, because recent budgets had not been fully funded, sometimes resolutions could not be implemented owing to a lack of funds. Moreover, resolutions often had a lifespan that extended beyond a single biennium, and when, for example, they called for scaling up of activities, additional funds had to be mobilized. She would work with Member States to develop a workable mechanism to overcome those challenges.

The CHAIRMAN took it that the Executive Board wished to request the Director-General to take into account comments made by the Programme, Budget and Administration Committee and Board members when preparing a revised Proposed programme budget 2012–2013 for submission to the Sixty-fourth World Health Assembly.

It was so agreed.

The Board noted the report.

3. FINANCIAL MATTERS: Item 7 of the Agenda

Scale of assessments for 2012–2013: Item 7.1 of the Agenda (Document EB128/25)

The CHAIRMAN drew attention to the account of the discussion of the item by the Programme, Budget and Administration Committee set forth in paragraph 21 of document EB128/3 and invited the Board to consider the draft resolution contained in document EB128/25.

Dr GEDEON (Seychelles), speaking on behalf of the Member States of the African Region, expressed concern that the most recent scale of assessments adopted by the United Nations, on which the proposed WHO scale for 2012–2013 was based, had included an increase for some African countries, which could lead to difficulties in payment as a result of the global financial situation. He welcomed a suggestion made previously by the Director-General regarding the establishment of a schedule of payments for those Member States that were unable to make one-off payments.

The CHAIRMAN took it that the Executive Board wished to take note of the report and adopt the draft resolution contained in document EB128/25.

The resolution was adopted.¹

The meeting rose at 12:30.

¹ Resolution EB128.R2.

EIGHTH MEETING

Thursday, 20 January 2011, at 14:40

Chairman: Dr M. KÖKÉNY (Hungary)

1. FINANCIAL MATTERS: Item 7 of the Agenda (continued)

Amendments to the Financial Regulations and Financial Rules: Item 7.2 of the Agenda (Documents EB128/3, EB128/26, EB128/26 Corr.1 and EB128/26 Add.1)

Dr MOHAMED (Oman), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, recalled the Committee's deliberations on the item (document EB128/3, paragraphs 22–24). The Committee had recommended that the Board adopt the amended resolution contained in paragraph 5 of document EB128/26, with the amended Annex to the resolution as contained in Annex 2 of the Committee's report.

The resolution, as amended, together with the amended Annex thereto, was adopted.¹

2. STAFFING MATTERS: Item 9 of the Agenda

Human resources: annual report: Item 9.1 of the Agenda (Documents EB128/3, EB128/31 and EB128/31 Add.1)

Dr MOHAMED (Oman), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee and recalling the Committee's deliberations on the item (document EB128/3, paragraphs 25–28), said that the Committee had recommended that the Board take note of the reports.

Dr SEEBA (Germany) commended the quality of the reports and, noting that any organization was only as good as its staff, highlighted the importance of the human resources strategy, which would link in to WHO's reform process. Staff learning and development formed crucial aspects of human resources management, enhancing staff members' potential and flexibility and facilitating rotation and mobility, which in turn improved the effectiveness of the Organization. A good mobility policy should promote movement of staff, including those in higher positions, within and across regions.

He welcomed the introduction of a revised policy on the prevention of harassment which should be integrated into the new strategy. The policy sharpened the focus on managers' responsibility to protect their staff and take corrective measures, and increased the options available to staff members. He further welcomed the fact that sound objective performance management would be part of the new strategy.

¹ Resolution EB128.R3.

He suggested that the extensive reporting requirements currently in force, as detailed in the informal background paper that had been issued, should be reduced in the interests of efficiency, given that it was the quality of reports that counted, not the quantity.

Dr GEDEON (Seychelles), speaking on behalf of the Member States of the African Region, welcomed the reports and the details of the innovative strategies. The emphasis on areas such as performance, knowledge sharing, learning and service excellence made for a modern and efficient human resources system. He noted the two parallel strategies for staff mobility and rotation.

The global rosters for generic positions at all levels of WHO and for both administrative and technical staff must be compiled fairly for all geographical regions. He looked forward to the results of the survey of staff members who had been recruited to WHO over the previous two years, which would permit a better understanding of the remaining obstacles to greater diversity.

The African Region, the latest to join the Global Management System, was grateful for the support that had been provided in preparing a comprehensive training programme for staff trainers.

Dr IBRAHIM (Somalia) said that WHO was a knowledge-based organization and that its staff were its most important asset. Emphasis should be placed on quality rather than quantity, but maintaining core staff should be a priority. The Fifth Committee of the United Nations General Assembly had accepted the recommendation of the International Civil Service Commission to harmonize the conditions of service of staff serving in non-family duty stations in the common system. The changes had been opposed by several field-oriented organizations, including FAO, UNESCO, WHO, UNICEF and UNFPA, and could lead to a significant decrease in the entitlements of current and future staff and in the quality of staff in the most difficult areas, such as in seven countries of the Eastern Mediterranean Region that were designated as non-family duty stations. Future reforms should not affect the already depleted staff levels in conflict-affected areas.

Dr ALI (alternate to Professor Haque, Bangladesh) welcomed the Secretariat's enhanced support for WHO's country operations through a more rational and strategic deployment of human resources, although the National Professional Officers system must be strengthened at the country level. The recruitment of qualified and experienced nationals to those posts in greater numbers would significantly boost country support.

He supported the compilation of a roster for the heads of WHO country offices, although in special circumstances regional directors should be allowed to recommend suitable candidates from among WHO staff who were not on the roster. Furthermore, as the head of the country office was required to work closely with the Regional Director and the receiving country, their choice should be given priority in such appointments. However, he acknowledged the need for continuous staff development. Conscious efforts should be made to promote recruitment from underrepresented countries, although candidates must fulfil the selection criteria.

He was pleased to state that the Regional Director had quickly taken steps to meet the concerns about the South-East Asia Region's human resources management that Bangladesh had raised at the previous Health Assembly. Bangladesh appreciated his leadership and efforts in those areas.

Dr JAMA (Assistant Director-General) recalled that senior management, including regional directors, had devoted considerable time and effort to developing the current human resources strategy, which would be revised in the light of evolving needs. Human resources were the most important asset of WHO, and the Organization was committed to managing its staff members properly to ensure that they were able to fulfil their roles satisfactorily. Quality would not be compromised in the recruitment process. No distinction was drawn between internationally- and nationally-recruited staff members at any level or in any category. WHO was striving to diversify in order to meet the specific needs of each country, placing emphasis on the technical and managerial proficiency of the staff it recruited. He acknowledged the support of rotation and mobility of staff and expressed the hope that the financial implications would not prohibit rotation, as the benefits outweighed the cost.

The growing number of non-family duty stations was a challenge across the United Nations system; recruiting good staff for them was difficult. The system of short-term rotation was currently being reviewed. System entitlements were granted in recognition of the fact that the staff members lived away from their families, and the Director-General would be considering how the recent decision of the United Nations General Assembly¹ on changes to the system could be implemented without eroding those entitlements.

The global roster for WHO country officers was working well: country officers would be assessed on the basis of standardized measures, ensuring that they had the necessary skills and technical, political and managerial expertise. The selection criteria had been clarified. The final decision on recruitment was taken by the Director-General on the recommendation of the regional directors. A system was also in place to provide staff members with training where necessary. The roster system would be extended to other categories of staff, including the general service and technical categories, in order to ensure harmonized standards and thereby facilitate rotation and mobility.

The Board noted the reports.

Report of the International Civil Service Commission: Item 9.2 of the Agenda (Documents EB128/3 and EB128/32)

The CHAIRMAN drew attention to the report and the comments of the Programme, Budget and Administration Committee (document EB128/3, paragraph 29).

The Board noted the report.

Amendments to the Staff Regulations and Staff Rules: Item 9.3 of the Agenda (Documents EB128/3, EB128/36 and EB128/36 Add.1)

The CHAIRMAN drew attention to two draft resolutions contained in paragraph 37 of document EB128/36. An amended version of the first of the two draft resolutions, proposed by the Programme, Budget and Administration Committee, was contained in paragraph 31 of the latter's report (document EB128/3). The financial and administrative implications of the two draft resolutions, were they to be adopted, were contained in document EB128/36 Add.1.

Dr MOHAMED (Oman), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee and recalling the Committee's deliberations on the item (document EB128/3, paragraphs 30–32), said that the Committee had recommended for adoption by the Board resolutions 1 and 2 contained in document EB128/31, with the proposed amendment to resolution 1. The Committee had further recommended a moratorium on the granting of continuing appointments until the Board had discussed the item at its next session, in May 2011.

Resolution 1, as amended, and resolution 2, as set out in paragraph 37 of document EB128/36, were adopted.²

The CHAIRMAN said that he took it that the Board wished to accept the proposal by the Programme, Budget and Administration Committee that a moratorium on the granting of continuing appointments be established until the Board had deliberated on the item in May 2011.

¹ United Nations General Assembly resolution 65/248.

² Resolutions EB128.R4 and EB128.R5, respectively.

It was so agreed.

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

Smallpox eradication: destruction of variola virus stocks: Item 4.9 of the Agenda (Document EB128/12)

The CHAIRMAN noted that three of the reports referred to in the Secretariat's report were available, in English only: "Scientific review of variola virus research, 1999–2010", "Advisory Group of Independent Experts to review the smallpox research programme (AGIES): comments on the scientific review of variola virus research, 1999–2010", and the report of the twelfth meeting of the WHO Advisory Committee on Variola Virus Research.

Dr GEDEON (Seychelles), speaking on behalf of the Member States of the African Region, welcomed the fact that WHO biosafety inspection teams had visited in 2009 the containment facilities at the two authorized repositories of the variola virus stocks – the Centers for Disease Control and Prevention in Atlanta, Georgia, United States of America, and the State Research Centre for Virology and Biotechnology in Koltsovo, Novosibirsk Region, Russian Federation – and concluded that the risk of accidental release of the virus from those sites was very remote. However, the world was facing the alarming possibilities that the virus potentially existed in places other than the two WHO-authorized sites and could be synthesized from scratch using publicly available information so as to reconstitute infectious virus. It would therefore be prudent to defer the destruction of the remaining variola virus in order to conduct further research and to gather evidence indicating that it could not be used for harmful purposes. The Director-General's call for a WHO smallpox laboratory network to be established was welcome and further testimony to the potential risks of a re-emergence of smallpox, which would demand a rapid response. The African Region, with its relatively weak health systems, would be particularly vulnerable. A response was urgently needed to the African Region's previously stated call for updated training of health professionals to renew skills in diagnosis, surveillance and treatment of smallpox, which had been all but lost following the global eradication of the disease. The African Region had also requested WHO to appoint at least one African member to the Advisory Committee on Variola Virus Research.

Dr ALHAJ HUSSEIN (alternate to Dr Said, Syrian Arab Republic), speaking on behalf of the Member States of the Eastern Mediterranean Region, commended all those involved in maintaining smallpox eradication and welcomed developments in research, such as DNA sequencing. As all the research that required variola virus stocks and diagnosis had been completed, there remained no need to retain stocks. The research had contributed greatly to the understanding of variola virus, and further research with live virus would have limited impact on public health and delay the destruction of stocks. Additional research would not require live variola virus. The Board should therefore review the schedule of research so that a final date could be set for the destruction of virus stocks.

Mr DESIRAJU (adviser to Mr Chandramouli, India) reaffirmed his country's commitment to the destruction of variola virus stocks as soon as possible. Even though the two authorized containment facilities had been found to be secure, the continued retention of the stocks with no definite time frame for their destruction was a matter for concern. The issue should therefore be kept on the Board's agenda until consensus was reached on the timing of destruction of stocks, pursuant to resolution WHA60.1.

Dr REN Minghui (China) commended the work of the WHO inspection teams and the Advisory Committee, and the review of research. That research had made significant progress in the molecular biology of variola virus, rapid diagnostics, vaccines and antiviral agents. The current challenge was to prevent a re-emergence of smallpox, to which end existing stocks must be destroyed when appropriate

and synthesis of the virus must be strictly prohibited. Use of the live virus should cease and the procedure for destroying existing stocks should be initiated, when appropriate. The Secretariat should give timely briefings on the latest research developments on the virus in order to enable Member States to enjoy the benefits of advances in diagnostics, antiviral agents and vaccines.

Mr YUSOF (Brunei Darussalam) said that, although he appreciated the wish of some Member States to retain stocks of variola virus, the benefits of doing so must be carefully balanced with the consequent threat to public health. He therefore agreed with other Member States of the Western Pacific Region that the remaining stocks should be destroyed, at an appropriate, agreed time.

Dr LUKWAGO (Uganda) said that it was important to retain stocks for use in further research in order to be prepared for any future re-emergence of smallpox. Current efforts should focus on safe storage of openly declared stocks and vigilance against additional, unauthorized stocks.

Dr DAULAIRE (United States of America) said that the discussion of the agenda item was consistent with the first of the seven key principles that he had identified in the Director-General's opening remarks: "prepare for the worst". That was the aim of the continuing programme of research using live variola virus. At the Sixty-fourth World Health Assembly in May 2011, Member States would consider whether global consensus existed on setting a date for destroying stocks at the two authorized repositories of live variola virus. The stocks were being retained in order to facilitate the completion of the research agenda that had been established in resolution WHA52.10 and reaffirmed in subsequent resolutions. The intentional release of variola from unsanctioned stocks remained a potential threat to the global community that required preparation for the worst. Given that the necessary tools to protect public health against that threat were not yet available, it was too early to set a date for destruction of the authorized stocks.

His Government continued to support retention of stocks in the two official repositories, which were necessary for outcome-oriented research. That position was supported by the scientific review of variola virus research 1999–2010, which concluded that research with live virus was needed to protect public health, and by an editorial in that week's issue of a leading scientific journal. The Health Assembly should authorize such retention until the research agenda was complete and public health officials possessed the necessary tools to respond appropriately to a potential smallpox outbreak.

The United States would continue to work with the Secretariat and other Member States to ensure that the results of relevant research and the consequent countermeasures were made available to all Member States. The United States also remained committed to the eventual destruction of all live variola virus stocks when the programme of research had reached its conclusion. United States scientists stood ready to answer any questions that members might have about the research agenda.

Ms BILLINGS (Canada) said that Canada supported the unanimous view of the WHO Advisory Committee on Variola Research that research for more effective vaccines required live virus, and agreed with the view held by some members of the Advisory Committee that the development of effective antiviral agents also required live virus. Since the technology existed to synthesize variola virus, the destruction of existing stocks of live virus would not prevent bioterrorism and would severely limit the response to any bioterrorist use of the virus. The decision on the timing of destruction of stocks should be postponed until it had been definitively established that they were no longer required for the purposes of public health research and that there were no proliferation concerns. She commended the report of the WHO Advisory Committee. That body should continue work under its current mandate.

Ms TOLSTOI (adviser to Professor Houssin, France) commended the high quality, clarity, precision and level of detail of the WHO scientific review of variola virus research. As the review indicated that the research had not yet been completed, it appeared to be premature to destroy the existing authorized stocks of variola virus, which should be retained on a temporary basis in order to complete the scientific research necessary for improving prophylactic and therapeutic measures and

diagnostic tools. However, in order to comply with previous decisions of the Health Assembly, the two repository centres should determine how much and which strains of virus were needed to continue their research and should provide a provisional date for the end of their work and the destruction of stocks. It further appeared from the various reports that measures to ensure the traceability of the strains and DNA held in the repositories must be strengthened. When a date for the destruction of stocks had been set, it would be necessary to establish a procedure for such destruction and a system of verification.

She supported the creation of a WHO smallpox laboratory diagnostic network, but requested further details concerning the laboratories and their mandate.

Dr TSESHKOVSKIY (adviser to Professor Starodubov, Russian Federation) commended the thorough review of research. Although smallpox had been eradicated more than 30 years earlier, concerns existed because of the natural mutability of orthopoxviruses pathogenic to humans and the possibility of bioterrorism in a world where half the population was not immune to variola virus. Significant progress had been made in the development of antiviral agents, but the search for better compounds and vaccines was not over. The Sixty-fourth World Health Assembly should decide to retain the two official stocks of live variola virus for research into safe and effective protective measures against variola virus in the event of a potential outbreak. The scientific review had concluded that further research should continue for public health purposes and, as the WHO biosafety inspection teams had concluded that the two authorized smallpox repositories were safe and secure for work with live variola virus, he argued for further and intensified national and international research using live variola virus in order to develop treatments and non-reactogenic vaccines as well as systems for type-specific identification of variola virus and other orthopoxviruses, and to improve animal models for testing antiviral agents and prophylactics. Only when those goals had been achieved could the decision to destroy official stocks of variola virus be taken. He fully supported the statement made by the member for the United States of America.

Mrs MATSAU (South Africa)¹ recalled that resolution WHA55.15 had authorized continued work on variola virus research provided that the research programme was conducted in a transparent manner under the guidance of WHO, and had called for a date for destruction of variola virus stocks to be set when the outcome of research so allowed. The report of the WHO Advisory Committee on Variola Virus Research detailed the state and progress of research into and with variola virus and contained a welcome proposal to establish a smallpox laboratory diagnostic network. The potential for synthesis of the full-length genome of variola virus, although illegal, meant that guidance on the safe keeping of the virus needed revision. The report failed to provide guidance on plans and policies for the destruction of variola virus stocks. She called for the WHO scientific review of variola virus research to be the final stage before establishing a date and procedure for the destruction of stocks. No further research proposal should be accepted after that review.

Dr FUKUDA (Assistant Director-General) recalled that the Health Assembly in resolution WHA60.1 had requested a major review. That and the report of the WHO Advisory Committee on Variola Virus Research contained extensive information on the progress of research and indicated areas where views converged or diverged, which should be considered carefully by technical staff in Member States. The question of when or whether variola stocks should be destroyed had to be discussed and decided upon by Member States themselves. The Secretariat would be available to provide any necessary assistance and technical advice to that end. In addition to facilitating discussion ahead of the Sixty-fourth World Health Assembly in May 2011, the aim was to ensure global preparedness for any kind of smallpox outbreak, through the stockpiling of vaccines and other measures.

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

In response to the request by France for more details on the nature of the proposed WHO smallpox laboratory diagnostic network, he said that the aim of the network would be to increase the capacity in all regions for early diagnosis of smallpox. He stressed that such a network would not require laboratories to store variola virus stocks, since they would be using molecular techniques that did not require the presence of virus.

The Board noted the report.

Malaria: Item 4.11 of the Agenda (Documents EB128/14 and EB128/14 Add.1)

The CHAIRMAN drew attention to the report in document EB128/14 which contained a draft resolution on the item. The financial and administrative implications of the draft resolution, were it to be adopted, were set out in document EB128/14 Add.1.

Dr ALI (alternate to Professor Haque, Bangladesh) noted that the burden of malaria was decreasing in many countries, indicating that Target 6.C of Millennium Development Goal 6 (Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases) was achievable provided that the coverage rates for WHO-recommended interventions were adequate. Malaria, both falciparum and vivax, was endemic in 13 border districts in Bangladesh, with a total of 10.9 million people at risk. Bangladesh was committed to achieving Target 6.C, through the National Malaria Control Programme. The Programme had set the target of 80% reduction of malaria cases and deaths by 2015, and it was expected that a 60% reduction would be achieved. Bangladesh appreciated WHO's technical support, but required long-term international support for malaria control, particularly for ensuring universal access to prevention, diagnosis and treatment, monitoring plasmodial drug resistance and insecticide resistance of vectors, improving human resources and strengthening capacities at the national and local levels. The Government was further aiming to improve interventions at the local level through community clinics, fostering partnerships with the private sector and civil society to boost malaria control and improving surveillance and cross-border collaboration.

Mr PRASAD (adviser to Mr Chandramouli, India) said that in India the target of Millennium Development Goal 6 of halting and reversing the trend of malaria had been achieved since 1996. In order to sustain and build on the gains, his Government planned to augment its malaria programme activities in such areas as the distribution and use of long-lasting insecticide-treated bednets, indoor residual spraying, insecticide resistance studies, biological control measures, diagnosis and treatment services, microscopy services at the primary health care level, sentinel surveillance sites, referral centres, and monitoring of drug resistance. Artemisinin monotherapy had been banned since 2009. Programme management had been strengthened at national, state, district and subdistrict levels by deploying trained technical staff with WHO's technical support.

He supported the draft resolution. In a country as large as India, with about 1.5 million cases of malaria a year, half of them falciparum, strategies had to be based on local conditions. He proposed that the first part of subparagraph 2(2) should be amended to read: "to harmonize the provision of support to countries for implementing WHO-recommended policies and strategies based on local endemicity of the disease".

Dr TAKEI (adviser to Dr Omi, Japan), noting that malaria control was vital for achieving Millennium Development Goal 4 (Reduce child mortality), especially in sub-Saharan Africa, said that his Government's technical assistance to various countries, provided either directly or through the Global Fund to Fight AIDS, Tuberculosis and Malaria, was expected to reduce malaria mortality by 3.3 million by 2015. In addition, the Japanese private sector was donating long-lasting insecticide-treated bednets widely to African countries. He expressed full support for the draft resolution, bearing in mind that prequalification was a useful and universally accepted process. Further efforts were needed to improve prequalification in order to strengthen the capacity of national and local industries

in cooperation with partners. Malaria was an important component in the achievement of Goal 4, especially in sub-Saharan Africa. Lessons learnt from malaria control could also be applied to control of other vector-borne diseases, including by integrated vector management.

Dr REN Minghui (China) said that China constantly experienced malaria outbreaks in border areas. In 2007, the Government had decided that patients with malaria should receive free treatment. It was also providing free medicines and insecticides in key areas, offering blood tests for patients with fever, and training personnel. Working with local government, it had also greatly improved malaria control capacity. Reported incidence continued to fall. With the support of WHO and the Global Fund to Fight AIDS, Tuberculosis and Malaria, China was aiming to eliminate malaria by 2020.

Currently, 18 countries were at the pre-elimination or elimination stage. Experience had shown, however, that the closer a country came to elimination, the more difficulties it encountered. Several technical issues remained to be resolved. He urged WHO to continue to coordinate the work of the relevant international organizations and countries, intensify financial and technical support for developing countries, and strengthen research. With regard to the draft resolution, he asked what was meant in subparagraph 1(3)(a) by “international quality standards”.

Dr GOPEE (Mauritius), speaking on behalf of the Member States of the African Region, said that, despite substantial progress globally in prevention and control of malaria, the disease remained a major public health problem in the Region, where most deaths occurred and it was the main cause of death for children under five years of age. Since 2008 the Roll Back Malaria Partnership’s Global Malaria Action Plan had led to the reinforcement of malaria control programmes through use of insecticide-treated bednets, indoor residual spraying and improved access to malaria interventions, resulting in a significant cut in transmission of the disease in sub-Saharan Africa.

Several challenges remained. Africa had to adopt a comprehensive approach based on vector elimination, with intensified efforts to ensure universal access to indoor residual spraying. Easy access to rapid diagnostic tests and microscopy had to be facilitated so as to allow treatment with artemisinin-based combination therapy, which must be available and affordable. The five-step Global Plan for Artemisinin Resistance Containment could be usefully implemented in the Region. With those measures, supported by rigorous surveillance, Africa should make faster and greater progress and aim for elimination.

As Mauritius had been malaria-free since 1997, its Malaria Control Programme aimed, through meticulous surveillance, early diagnosis, treatment and monitoring of drug resistance, integrated vector management, chemoprophylaxis for travellers, health education and capacity building, to prevent re-introduction of the disease.

Dr MAHFOUDI (adviser to Mr El Makkoui, Morocco) endorsed the recommendation that malaria-endemic countries should build on past gains to prevent the reintroduction of the disease. With regard to the draft resolution, he proposed the addition of a new, tenth, preambular paragraph to read: “Considering that the increase in international travel and South–North migration may re-introduce malaria in countries that had eliminated it”. The first part of subparagraph 3(1) should consequently be amended to request the Director-General to support the “development and updating of evidence-based norms, standards, policies, guidelines and strategies for malaria prevention, control, elimination, re-emergence and re-introduction”. The draft resolution should also express support for a global strategy to prevent the re-introduction of malaria in border areas and at airports, and for measures ensuring that effective medicines were made available at reasonable prices.

Mr AL-SHAMI (adviser to Dr Rasae, Yemen), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that malaria was still present in six countries in the Region – Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen – which needed strong support if they were to control the disease effectively. Recently the disease burden had been reduced slightly, through the use of artemisinin-based combination therapy and insecticide-treated bednets. Coverage, however, fell short of the 80% target, reflecting the insufficient allocation of resources to national health sectors.

Without sufficient human and material resources diagnostic and prevention activities, including social programmes, were impossible. Moreover, the incidence of malaria had risen owing to factors such as the floods in Pakistan and ongoing civil unrest in Somalia. Regional centres were needed to channel resources provided by the international community. WHO and other organizations should support control measures in border areas. Projects in some of the Region's countries had been successful: for example, malaria had been eliminated in Morocco and the United Arab Emirates and its incidence had been reduced in Iraq, the Islamic Republic of Iran, Saudi Arabia and Yemen.

He acknowledged WHO's training and support for education programmes, but many of the Region's Member States faced difficulties with planning, diagnosis and management of integrated management programmes. He called for more training in different languages. To eliminate malaria by 2012, the goal endorsed by the Regional Committee for the Eastern Mediterranean in 2008,¹ would require a high level of political commitment and sufficient financial resources.

He acknowledged the Secretariat's contribution to the successful submission by the Region's Member States to the Global Fund to Fight AIDS, Tuberculosis and Malaria for funding of 12 of 13 projects. Further efforts were needed in order to increase many national budgets for combating malaria, build on past achievements and prevent the re-emergence of the disease in malaria-free countries.

Mr YUSOF (Brunei Darussalam) said that his country was fully committed to maintaining its malaria-free status. The report, which usefully outlined the current situation and developments in malaria control and prevention, would enable Brunei Darussalam to review and strengthen its malaria vigilance programme, a particularly relevant task in view of the extent of global travel to and from malaria-endemic countries.

Morbidity and mortality rates due to dengue and dengue hemorrhagic fever, also mosquito-borne, were increasing, even in his country. The Secretariat and Member States should pay due attention to control and prevention of dengue, in line with resolutions WHA46.31 and WHA55.17, particularly in the absence of a cure and an effective vaccine. Dengue and malaria required similar control and prevention measures, and all Member States should continue to review and share best practices in order to protect those at risk.

Dr DE ASSUNÇÃO OSWALDO SAÍDE (Mozambique) proposed several amendments to the draft resolution that were supported by the members for Uganda and Kenya. A new tenth preambular paragraph should be added to read: "Recognizing that many pharmaceutical manufacturers, particularly in sub-Saharan Africa, have deployed significant efforts to ensure that their products are prequalified by WHO but have been unable to do so, and are thereby denied the opportunity to compete for the manufacture and supply of artemisinin combination therapies and other health products in the midst of increased funding, thus further undermining investment in pharmaceutical innovation in the countries affected". A new eleventh preambular paragraph should read: "Recognizing the resolution adopted at the 18th Roll Back Malaria Board Meeting on ACT Manufacturing in malaria-endemic countries".

Two new subparagraphs should be added under paragraph 1, to read: "(6) to establish or review legislation to increase the capacity of national regulatory authorities to provide support to local pharmaceutical manufacturers for increasing the quality of artemisinin combination therapies and other health products"; and "(7) to increase funding for research and development in malaria prevention, control and treatment".

He also proposed the addition of three new subparagraphs under paragraph 3, to read: "(5) to provide support for strengthening the capacities of manufacturers of artemisinin combination therapies and other health products in countries endemic for malaria so as to comply with the standards of the WHO prequalification programme"; "(6) to provide support, upon request, to National Regulatory

¹ Resolution EM/RC55/R.9.

Authorities in strengthening their capacity and leadership in Good Manufacturing Practice standards and the WHO prequalification process”; and “(7) to establish a high-level coordination mechanism with the United Nations Industrial Development Organization and Roll Back Malaria Partnership for advocating infrastructure development and the training of pharmaceutical manufacturers from countries endemic for malaria in order to increase access to artemisinin combination therapies and other health products”.

Dr DAULAIRE (United States of America) stressed the importance of global malaria control, especially for young children and women, and also given the disease’s adverse effect impact on household incomes, economic and social development and political stability. Despite the progress mentioned in the report, much more needed to be done to reduce the global burden of malaria, and Member States should continue expanding effective interventions and increase the resources allocated to its control.

He supported the Secretariat’s call for action to combat mosquito resistance to insecticides; it was essential to develop and implement a global plan for that purpose. Avoiding the use of pyrethroid insecticides for indoor residual spraying in areas in which long-lasting insecticide-treated bednets had been widely distributed among the population might eliminate an effective malaria control tool in countries where mosquitoes were susceptible to such insecticides and where malaria transmission seasons lasted five months or longer. Pyrethroid insecticides had to be maintained as an option for indoor residual spraying programmes, at least until newer, longer-lasting insecticides from other classes became available. The report seemed to underplay the value of indoor residual spraying; paragraph 7 could be construed to mean that indoor residual spraying was largely viewed as a supplement to long-lasting insecticide nets, which was not true. Likewise, subparagraph 1(2)(a) of the draft resolution failed to mention the need for indoor residual spraying.

As the largest donor to global malaria control efforts, his Government urged all donor and recipient countries to maintain their support for such efforts through appropriate financial contributions and stronger political commitment. The affected countries, particularly in Africa, should increase their domestic spending on malaria control as part of their overall efforts to boost their national budget allocations for health.

He supported the draft resolution and would submit a minor amendment to the Secretariat. He needed, however, to review the proposed amendments to ensure they did not weaken WHO’s vital role in prequalification.

Dr ST JOHN (Barbados) emphasized the importance of malaria prevention and control for achieving several of the Millennium Development Goals. Although malaria was neither indigenous to or transmitted in her country, a weak wetlands vector, *Anopheles aquasalis*, did breed there. The national malaria control programme therefore included vector control of wetlands and the airport, provision of advice to travellers and prophylaxis for international travellers, and surveillance. She supported the draft resolution.

Dr TSESHKOVSKIY (adviser to Professor Starodubov, Russian Federation) said that, although the Russian Federation and the other countries of the former Union of Soviet Socialist Republics had been malaria-free for many years, the situation had changed. It supported the efforts being made by several malaria-endemic countries, with the financial and technical support of the Secretariat, to control the disease through vector control, treatment programmes, and the application of indicators of the reduction of morbidity and mortality. Some countries, including some in the European Region, had made considerable progress towards the elimination of malaria by 2015, in line with the Millennium Development Goals. His country’s activities included promoting measures such as research into the causes of plasmodial drug resistance, new insecticides, the strengthening of human resources, entomological monitoring, and epidemiological surveillance. Between 2007 and 2010 it had for the first time allocated significant funding for a special programme, undertaken with WHO, to train specialists in the planning, monitoring and assessment of the effectiveness of anti-malaria measures in African countries endemic for malaria. WHO training courses for specialists from Asia and Africa had

been held in Moscow in the past two years, and the feedback from those involved in the WHO malaria control programme had been very positive. The Russian Federation stood ready to expand its technical assistance and endorsed the draft resolution.

Dr NARVÁEZ (Ecuador), referring to the successful malaria control strategies implemented in Ecuador with the help of PAHO and support from the Global Fund to Fight AIDS, Tuberculosis and Malaria, proposed the insertion of additional wording in paragraph 1 of the draft resolution, to read: “to promote cooperation and the exchange of information between countries, especially those with shared borders, in order to develop an integrated approach to the problem”.

Mr SCHOLTEN (alternate to Dr Seeba, Germany) proposed several amendments to the draft resolution: in subparagraph 1(1), replace “predictable long-term” with “adequate”; in subparagraph 1(5), add “where appropriate” after “at all levels of the healthcare system”; add a new subparagraph 1(6bis), to read: “to comply with existing commitments and international regulations on the use of pesticides”; in subparagraph 2(1), replace “sufficient and predictable” with “adequate”; add a new subparagraph 2(5), to read: “to focus on particularly vulnerable populations in high-burden countries, such as tribal people threatened by forest malaria and people in fragile situations”.

Mr BABLOYAN (Armenia) thanked WHO and other partners that had helped Armenia to become malaria-free. He supported the draft resolution.

Dr RAZAFINDRAZAKA (Madagascar)¹ endorsed the amendments proposed by countries from the African Region. Malaria had been one of the most deadly diseases in Madagascar, especially in rural areas, but, thanks to international aid, the situation had changed completely and the disease was gradually being controlled. Preventive and vector-control activities had been launched, insecticide-treated bednets were distributed regularly year-round, and diagnostic tests and antimalarial medicines were available from the public services.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran)¹ said that malaria could not be controlled and eliminated through national strategies alone, which might even be counterproductive, since one country’s strategy might not be the same as that of its neighbours. In the case of insecticides, the result could be resistance. Subregional planning was of the utmost importance, especially in the control and elimination phases and in border areas between countries. His country had therefore set up the G5 Health Cooperation Forum, which included Afghanistan, Pakistan and Iraq as members and in which the Regional Office for the Eastern Mediterranean participated. The Forum had recently finalized its cooperation plan in Tehran.

Ms OSUNDWA (Kenya)¹ endorsed the amendments proposed by the member for Mozambique.

Dr NAKATANI (Assistant Director-General), responding to comments, underlined the value of partnerships. He agreed with the member for Bangladesh that malaria control was important for the achievement of Millennium Development Goal 6, and with the member for India that it was important to sustain and build on past gains. The draft resolution had been written in that spirit.

The member for the United States of America had been right to underscore the importance of indoor residual spraying; DDT was a useful and usable means to that end as long as the provisions of the Stockholm Convention on Persistent Organic Pollutants were respected. The draft resolution would be amended to reflect that point.

He agreed with the member for Brunei Darussalam about the value of malaria control work for other diseases such as dengue, of which there were some 50 million cases a year – a significant public

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

health problem. Interventions, especially vector control, would help to reduce the incidence not just of dengue but also other mosquito-borne diseases like Japanese encephalitis and lymphatic filariasis.

In response to the member for China, he explained that the term “international quality standards” referred to prequalification by WHO, which was the basis for the amendments put forward by members for countries in the African Region. Prequalification was a universal, globally accepted standard that was applied by all countries in all regions. A further important component of WHO’s prequalification programme was national capacity building, which was the focus of a workshop currently being held in Copenhagen for national legislators from many countries.

The CHAIRMAN invited the Board to take note of the report and suggested that further consideration of the item be postponed until the revised draft resolution had been made available to members.

It was so agreed.

(For continuation of the discussion, see the summary record of the tenth meeting.)

Cholera: mechanism for control and prevention: Item 4.10 of the Agenda (Documents EB128/13, EB128/13 Add.1, EB128/13 Add.1 Rev.1 and EB128/13 Add.2) (continued from the fourth meeting)

The CHAIRMAN invited the Board to resume its consideration of the item on the basis of the amended draft resolution set out in document EB128/13 Add.1 Rev.1.

Mr KAZI (adviser to Professor Haque, Bangladesh) thanked the members for France, Hungary, India, Morocco and the United States of America, and the representatives of Spain, Thailand and the United Kingdom of Great Britain and Northern Ireland for their substantive contributions to the draft resolution. He read out other amendments which had been received after document EB128/13 Add.1 Rev.1 had been issued: in subparagraph 1(5), add “in line with Article 43 of the International Health Regulations (2005)” after “public health concerns”; in subparagraph 2(4), insert “effective” before “vaccine deployment”; amend subparagraph 2(8) to read: “to develop updated and practical evidence-based policy guidelines, including the feasibility and assessment of the appropriate and cost-effective use of oral cholera vaccines in low-income countries and the definition of target groups”; and amend subparagraph 2(9) to read: “to liaise with relevant international funding agencies for possible support for introducing effective cholera vaccines in low-income countries”.

Dr DAULAIRE (United States of America) said that the amended version of the draft resolution had been sent to the Centers for Disease Control and Prevention in Atlanta, Georgia, for review. The new amendments would also have to be sent there. He asked the Board’s indulgence as he was unable to take a position until he had received a response.

The CHAIRMAN suggested that further consideration of the amended draft resolution should be postponed pending a final review by all members of the proposed amendments.

It was so agreed.

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

Eradication of dracunculiasis: Item 4.12 of the Agenda (Documents EB128/15 and EB128/15 Add.1)

The CHAIRMAN invited the Board to consider the report and draft resolution set out in document EB128/15. The financial and administrative implications for the Secretariat of the draft resolution, should it be adopted, were set out in document EB128/15 Add.1.

Dr DAULAIRE (United States of America) expressed support for the goal of eradicating dracunculiasis and the draft resolution. Great progress had been made, and he congratulated the countries in which elimination had been certified as well as those that had reached the pre-certification stage. Their efforts demonstrated the effectiveness of the basic interventions used by national dracunculiasis eradication programmes, the Secretariat and their partners.

The troubling news of a cluster of cases of locally transmitted dracunculiasis in 2011 in one area of Chad underlined the need for vigilance in surveillance activities and case containment in both disease-endemic areas and the dracunculiasis-free zones surrounding them. The Secretariat should continue to engage Member States, partners and donors to enhance support for disease detection and prevention activities, which included both case containment and the provision of safe water supplies in communities at risk.

He supported the draft resolution.

Dr DE ASSUNÇÃO OSWALDO SAÍDE (Mozambique), speaking on behalf of the Member States of the African Region, observed that the annual incidence of dracunculiasis had declined remarkably in the Region. Nevertheless, despite the joint efforts made at national and international levels under the 2004 Geneva Declaration on Guinea-Worm Eradication, the disease persisted in four countries, namely Chad, Ethiopia, Ghana and Mali. Eradication was contingent on improved economic and social conditions, a better supply of drinking-water, which was lacking in many parts of the dracunculiasis-endemic countries, and greater security. In addition, those affected were mostly nomadic communities lacking social and health facilities for personal hygiene. In view of current trends, Ethiopia, Ghana and Mali were likely to achieve eradication by the end of 2011. That accomplishment would have only been possible thanks to the support of many donors and partners, the commitment of the countries concerned, and ongoing WHO technical assistance. In the final push to reach eradication, which would mark another milestone in public health history, it was vital to maintain the commitment of international partners and donors to make available the resources needed to increase the availability of safe drinking-water, improve surveillance for case detection and containment, strengthen other interventions and heighten public awareness.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland)¹ expressed satisfaction at the progress made towards eradication but stressed that more needed to be done. The international community had to ensure unwavering support and to close the funding gap, so as to maintain steady progress and the necessary levels of surveillance in the remaining dracunculiasis-endemic countries. WHO should identify the lessons to be learnt for application, where appropriate, to other neglected tropical diseases. Those lessons might include: the importance of good, accurate community reporting; a national commitment to simple interventions based on good information, education and communication, improved provision of clean water, case containment, simple filtration methods and the role of community health workers; and the demonstration by the above measures that such diseases could be controlled without the need for vaccines and diagnostics.

Mrs REITENBACH (adviser to Dr Seeba, Germany) applauded the progress made towards eradication of dracunculiasis and endorsed the draft resolution.

Dr NAKATANI (Assistant Director-General) said that dracunculiasis, which affected the poorest of the poor, typified a neglected tropical disease. Strong partnerships, surveillance and public health measures were moving the world towards eradication, but he agreed that the outbreak in Chad was alarming. That country's health ministry, the Secretariat and its partners were making every effort to determine the full extent of the outbreak and take appropriate action; surveillance and containment had already been strengthened.

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

The Board noted the report.

The CHAIRMAN said that he took it that the Board wished to adopt the draft resolution contained in document EB128/15.

The draft resolution was adopted.¹

The meeting rose at 17:10.

¹ Resolution EB128.R6.

NINTH MEETING

Friday, 21 January 2011, at 09:10

Chairman: Dr M. KÖKÉNY (Hungary)

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

Cholera: mechanism for control and prevention: Item 4.10 of the Agenda (Documents EB128/13, EB128/13 Add.1 Rev.1 and EB128/13 Add.2) (continued from the eighth meeting, section 3)

Dr DAULAIRE (United States of America) said that, having consulted on the amendments proposed by the member for Bangladesh, he confirmed that the proposed language changes were acceptable. He requested, however, that the words “and water” should be included before “safety measures” in paragraph 2(6).

Dr ALI (alternate to Professor Haque, Bangladesh) thanked the member for the United States of America for his constructive suggestion.

The CHAIRMAN took it that the Board wished to adopt the draft resolution with the agreed amendments.

The resolution, as amended, was adopted.¹

Public health, innovation and intellectual property: Consultative Expert Working Group on Research and Development: Financing and Coordination: Item 4.3 of the Agenda (Document EB128/6) (continued from the third meeting, section 1)

The CHAIRMAN, inviting the Board to resume consideration of the item, said that the Secretariat would present detailed information on the implementation to date of the global strategy and plan of action on public health, innovation and intellectual property. The selection criteria applied in respect of candidates for the Consultative Expert Working Group on Research and Development: Financing and Coordination and the handling of conflicts of interest would also be outlined.

Dr KIENY (Assistant Director-General), in an illustrated presentation, said that establishing the Consultative Expert Working Group on Research and Development: Financing and Coordination was one of the eight core elements of the global strategy and plan of action on public health, innovation and intellectual property.

Since the last progress report on implementation, which had been presented at the Sixty-third World Health Assembly,² several activities had been undertaken in the areas of prioritization and capacity building for research and development, local production and transfer of technology, and management of intellectual property for public health. A new model was being piloted for vaccine-

¹ Resolution EB128.R7.

² Document A63/6; see also document WHA63/2010/REC/3, summary records of the second meeting (section 2) and twelfth meeting (section 3) of Committee A.

technology transfer using a hub approach rather than the traditional bilateral model. WHO had facilitated the establishment of the technology-transfer hub for vaccine adjuvants in 2010, which complemented the hub previously established in 2008 for influenza vaccines. Capacity-building grants had been provided to developing-country vaccine manufacturers in 11 countries.

Since May 2010, 32 medicines and 11 vaccines from developing countries had been prequalified, as had six quality-control laboratories. A project supported by the European Commission on improving access to medicines in developing countries would be completed by May 2011. A public health framework for supporting local production was being elaborated; a capacity-building phase would run until the end of 2013 with respect to local production and technology transfer, with specific health products being targeted.

On the issue of management of public health, innovation and intellectual property, a series of symposia had been initiated between UNDP, WIPO, WTO, UNCTAD and UNAIDS. Guidance on the use of the flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) in improving access to HIV/AIDS treatment was due to be published in February 2011. Regional and subregional training workshops had been held for developing-country policy-makers, and technical advice would be provided to individual Member States on how to implement their obligations under the TRIPS agreement while safeguarding public health interests.

Work was under way on various other initiatives, including support to the African Network for Drugs and Diagnostics Innovation, creating an innovation platform for the Americas in collaboration with the Regional Office of the Americas and PAHO, establishing additional centres of excellence on research and development and transfer of technology in the developing world, holding capacity-building workshops on the TRIPS agreement and public health, and designing a global web portal on local production and transfer of technology.

The global strategy and plan of action needed to be implemented at national, regional and global levels; the period 2011–2012 would be a pilot phase preceding broader action in 2013–2015. Implementation would comprise national assessments, gap analysis and technical assistance at country level, documentation of national case studies with identification of good examples, mainstreaming of the global strategy and plan of action within WHO and in external collaborative arrangements, and formulation of a monitoring and evaluation framework and a web-based portal.

The 21 experts to constitute the Consultative Expert Working Group on Research and Development: Financing and Coordination had been selected in accordance with resolution WHA63.28, taking into account regional representation, gender balance and diversity of expertise. Member States had submitted the names of 79 individuals to the Secretariat. As to conflicts of interest, the Working Group would use the revised procedure that had been implemented in the Secretariat in recent months. All declarations of interest received from the experts would be analysed before the composition of the Group was finalized in order to assess whether there were any characteristics that would preclude or restrict the participation of any person in the Group. Updated declarations of interest would be regularly required from members of the Group who would, if necessary, be requested to abstain from certain discussions or decisions if any potential conflict existed, as was common practice within WHO.

She informed the Board that the curricula vitae of the experts listed in the report had been posted on WHO's web site the previous day.

Mrs ESCOREL DE MORAES (adviser to Dr Buss, Brazil) thanked the Secretariat for its prompt response to requests for a presentation on the implementation of the global strategy and plan of action, which should be made available to all Member States. She also expressed appreciation for the uploading on the web site of the curricula vitae of candidates for the Consultative Expert Working Group on Research and Development: Financing and Coordination, but reiterated that, for the sake of transparency and confidence building, all information on the professional background of the experts should have been submitted to Board members for consideration before the current session.

The financing and coordination of research and development was a central element of the global strategy and plan of action and the Working Group offered an opportunity to consider innovative new ideas and change established paradigms. Its conclusions should have a positive impact on equity in

health and access to medicines. Nevertheless, she reiterated her Government's discomfort with the selection of at least one expert from the pharmaceutical industry. Pharmaceutical manufacturers made an important contribution to global public health, but they were guided by corporate interests, namely ensuring profit for shareholders, which was a clear conflict of interest. It was therefore regrettable that some Member States had decided to nominate experts with direct links to that industry or who had presented proposals that would be evaluated by the Working Group. All proposals should be reviewed from a public health perspective and such an approach should be observed by all experts.

In order to ensure an independent evaluation and an outcome that can be trusted, Brazil placed particular emphasis on the transparent management of potential conflicts of interest through full compliance with the mechanisms established by the Director-General, including the recently updated WHO Guidelines for Declaration of Interests (WHO experts). When the declarations by experts of any such interests were evaluated, the Secretariat must comply fully with the Guidelines, by not allowing or by limiting the participation of those experts with clear ethical or legal incompatibilities in the tasks mandated by Member States. She requested that a briefing on the mechanisms established for the purposes of managing conflicts of interests be organized before the next Health Assembly.

She keenly awaited the submission of the workplan for the Consultative Expert Working Group on Research and Development: Financing and Coordination to the Executive Board at its 129th session, a progress report to the Board at the 130th session and a final report at the Sixty-fifth World Health Assembly.

The CHAIRMAN invited the representative of Thailand to elaborate on the statement he had made in the second meeting of the Board.

Dr VIROJ TANGCHAROENSATHIEN (Thailand)¹ said that he had made his earlier statement not with a view to removing any name from the list of experts proposed but to raise his Government's concerns, which echoed those expressed by the member for Brazil. Nobody was free from conflict of interest whether he or she was from a private industry background and interested in maximizing profits or from nongovernmental organizations or civil society, which favoured public interests. In such a context it was therefore important that conflicts of interests were managed in an appropriate and transparent manner.

Review of the guidelines applied to managing conflicts of interests of several agencies, including OECD and the United States National Institutes of Health as well as WHO's own Guidelines, identified several procedures that could be usefully applied by the Working Group, namely: any conflict of interest should be disclosed upon entry to the Working Group, as had been WHO's standard practice for comparable groups for several years; a written declaration of interests should be provided at the beginning of each meeting of the Working Group; the chairman of the Working Group should establish the existence of any conflict of interest among members before any decision taken by the Working Group and should then ensure that any member removed himself or herself from the room when a conflict of interest existed in relation to the decision to be taken; and a provision should exist whereby any member demonstrating a clear conflict of interest should be asked to leave the Working Group.

Other mechanisms to improve the performance of the Working Group should be developed. The chairman of the Group should be able to suggest to the Director-General the removal of any member from the Group who was not performing at the required level, for instance, non-attendance at more than two meetings. A video link could be established during public meetings of the Working Group in order to allow Member States to observe the Group's deliberations; private sessions in which decisions were taken remaining closed to Member States.

The Working Group needed a strong and impartial chairman.

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

Dr NARVÁEZ (Ecuador) supported the comments made by the member for Brazil. It was vital to avoid conflicts of interest in establishing the group of experts. The Member States of the Union of South American Nations expected the Working Group to demonstrate a positive approach if it were to achieve the best possible results.

Dr KIENY (Assistant Director-General) said that the Secretariat would undertake to manage conflicts of interest in a transparent manner, as underlined by speakers and in accordance with the revised WHO Guidelines for Declaration of Interests (WHO experts) issued in June 2010.

Responding to the representative of Thailand she confirmed that the Secretariat would look into the possibility of establishing video links for public sessions of the Working Group.

Transparent, regional web-based consultations would take place in order to gather comments on the proposals put forward to the Working Group, and the Secretariat would continue to rely on the guidance of Member States as the process continued.

The CHAIRMAN took it that the Board wished to note the report and to approve the proposed roster of experts, taking into consideration the issues raised during its discussions.

It was so decided.

Leprosy (Hansen disease): Item 4.13 of the Agenda (Document EB128/16)

Dr ALI (alternate to Professor Haque, Bangladesh) welcomed the outcome of the eighth meeting of the Expert Committee on Leprosy, particularly its recommendations on reducing the rate of occurrence of new cases with visible disability (WHO Grade 2 Disability) to below one case per million population globally; paying greater attention to equity, social justice, human rights, stigmatization and gender issues; and the increased contribution of people affected by leprosy in decision-making processes.

The leprosy elimination target had been achieved in Bangladesh in 1998, two years ahead of the global target. Even though Bangladesh ranked fifth in the world in the number of cases of leprosy diagnosed annually, only four districts reported a prevalence that exceeded the elimination target.

Achieving the target globally would largely depend on the success of countries in South-East Asia. The control strategy should focus on integrating basic services into primary health-care settings. The following elements would be crucial in implementing the Enhanced Global Strategy for further Reducing the Disease Burden due to Leprosy (2011–2015): molecular biological research to improve diagnostics; research into subclinical infection and new treatments, with clinical trials of both prophylactic and therapeutic agents; provision of technical support to Member States in reducing stigmatization of and discrimination against patients with leprosy and their families; intensified case detection in leprosy-endemic pockets in countries with large numbers of new cases; capacity-building at national and subnational levels; and resource mobilization.

Mr DESIRAJU (adviser to Mr Chandramouli, India), endorsing the comments made by the member for Bangladesh, said that WHO's proactive role had provided the necessary political and financial commitment to controlling leprosy.

India's leprosy programme focused on areas of high endemicity, with early case detection, provision of full treatment to patients, awareness campaigns and training. He supported efforts by WHO to halve the duration of treatment regimens to six months and requested the Secretariat to expedite research and clinical trials.

India was a signatory to the United Nations Human Rights Council resolution 8/13, on elimination of discrimination against persons affected by leprosy and their family members, and he was pleased to report that stigmatization of people with leprosy was gradually decreasing in the country. The goal of elimination had been achieved, but extra effort was needed for eradication.

Dr MAHFOUDI (adviser to Mr El Makkoui, Morocco), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the Region had one of the lowest rates of morbidity for leprosy and had already achieved the elimination goal by reaching a prevalence of one case per 10 000 population. However, in some countries, notably Afghanistan, Somalia and Sudan (where more than 1000 cases were still being diagnosed each year), lack of resources and the low priority assigned by health ministries, made implementation of control strategies difficult, particularly in regard to diagnostics and treatment.

He supported the recommendations made by the Committee of Experts, particularly on setting new international targets to reduce prevalence to below one case per million population by 2012 and on multidrug treatment. Attention also needed to be given to countering stigmatization and discrimination and to gender issues.

Dr REN Minghui (China) said that China had achieved the target for leprosy elimination in 1998, reporting around 1600 cases each year in recent years, and the Government was committed to eliminating the disease in provinces of high endemicity. He welcomed the report's recommendations to devote greater attention to areas of high endemicity in countries that had achieved the target as well as those that had not yet done so.

The Secretariat should convene experts in research and development of rapid diagnostics in order to improve early detection and standardize treatment regimens. The Secretariat should also support countries in providing prevention measures, including chemoprophylaxis, for all those in close contact with leprosy patients, and in scaling up publicity campaigns aimed at eliminating discrimination and protecting the rights and interests of those with the disease.

Mr YUSOF (Brunei Darussalam), observing that progress towards achieving the global target was encouraging, pledged his country's full support to continuing the initiative.

Mr HAGE CARMO (adviser to Dr Buss, Brazil) welcomed the report. The indicators proposed would make it possible to identify the most vulnerable population groups and enable the global community to progress towards controlling leprosy. Brazil was already applying some of the indicators and strategies proposed by the Committee of Experts and had seen a significant reduction in the burden of the disease nationally.

Dr TAKEI (adviser to Dr Omi, Japan) said that the recommendations of the Committee of Experts to have indicators on disability grading were appropriate, as that approach would attract more political commitment to eliminating leprosy and lead to wider recognition that leprosy was not a disease of the past. The Grade 2 disability indicator, although useful as a global goal for 2020, was not representative of total leprosy prevalence and it would therefore be important to monitor also all reported new cases and the rate of occurrence per 100 000 population. Further targets should be set in that regard to be achieved globally by 2015.

Japan continued to contribute to global leprosy control through bilateral assistance and by carrying out research and development in that field.

Dr BIRINTANYA (Burundi), speaking on behalf of the Member States of the African Region, said that in 2005 all those Member States had achieved the target of prevalence of less than one case per 10 000 population, thanks to the introduction of better medicines through partnerships and sound programmes. Leprosy was concentrated in certain areas, remaining endemic in some, but case detection rates were generally falling, except in countries where leprosy control was no longer considered a priority. The inclusion of leprosy in primary health care services remained limited and there were still socioeconomic and cultural issues to be overcome. Management of complications of the disease was hindered by a lack of financial and human resources. Therefore, he called for a new plan of action for control of leprosy, which took account of the disease's geographical distribution; the strengthening of national capacities; increased availability of effective and affordable medicines; and the maintenance of strong political commitment.

Dr NAKATANI (Assistant Director-General) thanked Member States for their comments and suggestions. Responding to points raised by the members for China and India on research and development, he said that WHO's current priorities in that area were diagnostics, monitoring of the effectiveness of medicines, and biomedical developments that could be used in leprosy control. WHO was expanding its collaboration with development research partners.

Several human rights challenges remained but measures had been taken to overcome discrimination, including the adoption of United Nations Human Rights Council resolution 8/13 on elimination of discrimination against persons affected by leprosy and their family members. WHO strongly advocated that any such discrimination was neither acceptable nor justifiable.

Responding to the member for Japan with regard to monitoring indicators, he said that the Grade 2 disability indicator recommended by the Committee of Experts would be highly useful in monitoring the incidence of disability caused by leprosy, which would have positive implications for the welfare of affected persons.

The CHAIRMAN took it that the Board wished to note the report.

The Board took note of the report.

Prevention and control of noncommunicable diseases: WHO's role in the preparation, implementation and follow-up to the high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases (September 2011): Item 4.14 of the Agenda (Document EB128/17)

The CHAIRMAN drew attention to a draft resolution proposed by Barbados, Monaco, Norway and the Russian Federation, which read:

The Executive Board,
Having considered the report on prevention and control of noncommunicable diseases,¹

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

The Sixty-fourth World Health Assembly,

PP1 Having considered the report on WHO's role in the preparation, implementation and follow up to the high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases;

PP2 Recalling and reaffirming resolution WHA61.14 on the prevention and control of noncommunicable diseases: implementation of the global strategy;

PP3 Noting the call by the Heads of Government of the Caribbean Community for inclusion of noncommunicable diseases in the outcome declaration of the Fifth Summit of the Americas (Port of Spain, 2009) and in the agenda of the high-level meeting of the United Nations General Assembly in 2011;

PP4 Recalling the Ministerial Declaration adopted at the 2009 high-level segment of the United Nations Economic and Social Council, which called for urgent action to implement the global strategy for the prevention and control of noncommunicable diseases and its related action plan;

PP5 Further recalling United Nations General Assembly resolution 64/265 in which the General Assembly decided to convene a high-level meeting of the General Assembly in September 2011, with the participation of Heads of State and Government,

¹ Document EB128/17.

on the prevention and control of noncommunicable diseases, as well as resolution 65/238 on the scope, modalities, format and organization of the high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases;

PP6 Noting the regional consultations held in collaboration with Member States with the support of United Nations Regional Commissions, United Nations agencies and entities in providing input to the preparations for the high-level meeting;

PP7 Noting the importance of the First Global Ministerial Conference on Noncommunicable Diseases and Healthy Lifestyles (Moscow, 28–29 April 2011);

PP8 Underscoring the need for a concerted and coordinated response at the national, regional and global levels in order to adequately meet the developmental and other challenges posed by the increasing global burden of noncommunicable diseases, in particular the following four: cardiovascular diseases, cancers, chronic respiratory diseases and diabetes;

PP9 Aware that policies in sectors other than health have a major bearing on the risk factors and social determinants of noncommunicable disease and recognizing the pressing need to strengthen sectoral collaboration at the highest level;

PP10 Recognizing that global targets and indicators need to be established in order to prevent illness, reduce disability, and halt and begin to reverse premature deaths from noncommunicable diseases;

PP11 Mindful of the links between noncommunicable diseases and poverty, and the fact that noncommunicable diseases are a threat to development;

PP12 Recognizing the leadership of WHO as the primary specialized agency for health and welcoming its role and efforts in promoting public health,

1. URGES Member States:

- (1) to identify the challenges, opportunities, and actions to be recommended for integration of the prevention and control of noncommunicable diseases into the development agenda at national, regional and international levels;
- (2) to strengthen political commitment to integrated prevention and control of noncommunicable diseases as part of the health and development agenda;
- (3) to implement the global strategy for prevention and control of noncommunicable diseases and ensure the active engagement of non-health sectors such as finance, trade, agriculture, education, urban development and industry, and the private sector, as well as civil society and nongovernmental organizations;
- (4) to support the preparations at national, regional and international levels for the high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases;
- (5) to raise awareness about the importance of attendance of the Heads of State and Government at the high-level meeting in September 2011 and inclusion on national delegations of parliamentary representatives of health and non-health sectors and others from civil society and academia;

2. REQUESTS the Director-General:

- (1) to work closely with partner agencies in the multilateral system on appropriate measures that address the increasing global burden of noncommunicable diseases and advocate for the inclusion of this topic on the global development agenda;
- (2) to develop standardized indicators to monitor noncommunicable diseases and their risk factors to assess the progress countries are making to prevent and control noncommunicable diseases;
- (3) to review and disseminate the evidence on the global status and trends of noncommunicable diseases with particular focus on development and the

challenges and social and economic impacts, emphasizing the relevance of this information to other sectors;

(4) to promote research on the prevalence, magnitude and risk factors of noncommunicable diseases, particularly in the context of developing countries;

(5) to review international experience and disseminate lessons learnt on effective mechanisms to promote intersectoral action for noncommunicable disease interventions;

(6) to urgently review WHO's capacity at country and regional levels to provide Member States with technical assistance and normative advice concerning prevention and control of noncommunicable diseases, including, but not limited to, that needed for health system strengthening;

(7) to continue dialogue and consultation with civil society and nongovernmental organizations while strengthening their contributions and input to the preparations for the high-level meeting of the United Nations General Assembly in September 2011.

He suggested that Member States should submit any amendments in writing so that they could be consolidated into a revised version and discussed in a subsequent meeting.

Dr ST JOHN (Barbados) said that the report demonstrated the type of strong leadership that WHO must continue to provide at the global decision-making level. She requested that the annexed chronology of events make reference to the fact that in July 2009 Member States of the Caribbean Community had resolved to urge the United Nations General Assembly to consider prevention and control of noncommunicable diseases and had urged inclusion of the subject in the declaration issued at the Fifth Summit of the Americas. The resolution to hold a high-level United Nations meeting¹ had been received with enthusiasm in the Region of the Americas and the Caribbean Community. PAHO had provided invaluable support to regional efforts. She looked forward to the United Nations Summit Regional Member States Consultation due to be held in Mexico City late in February 2011. She further recognized the leadership of the Russian Federation in organizing the First Global Ministerial Conference on Noncommunicable Diseases and Healthy Lifestyles, to be held in Moscow in April 2011.

Barbados was pleased to introduce the draft resolution. She called on Member States to support multisectoral preparations at the national level to ensure that their Heads of Government were properly briefed in preparation for the high-level meeting. She looked forward to receiving the Director-General's reports on consultations with nongovernmental organizations and the private sector, which would provide valuable input for national and regional consultations. The Secretariat would presumably mobilize technical and financial resources in order to ensure the most fruitful participation by Member States in the high-level meeting, and a report in that respect would be appreciated. Continued support by WHO of the high-level meeting would ensure maximum impact of efforts to combat the scourge of noncommunicable diseases.

Dr AL BITTAR (adviser to Dr Said, Syrian Arab Republic), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that increased prevalence of noncommunicable diseases in that Region was negatively affecting development and the ability to attain the Millennium Development Goals; they accounted for 50% of deaths and were increasing the burden of illness. Across the Region, the advisability of incorporating noncommunicable disease strategies into national and regional plans was being emphasized; political commitment to the control of noncommunicable diseases needed to increase, with governments, civil society and the private sector working together. The Region had begun preparatory work for the high-level meeting of the United Nations General

¹ United Nations General Assembly resolution 64/265.

Assembly on the prevention and control of noncommunicable diseases and had been reviewing those diseases and their impact on economic and social plans in the Region.

The Secretariat should provide assistance to Member States on the prevention, early diagnosis and treatment of noncommunicable diseases. A multisectoral approach would facilitate changes in both health-related and social behaviours and a reduction in prevalence of those diseases and the cost of their treatment. Effective surveillance systems would also help to reduce morbidity.

In his country noncommunicable diseases were the main cause of morbidity and mortality, accounting for 79% of deaths. Their control needed health systems based on preventive measures, healthy behaviours and early detection mechanisms; his Minister of Health had undertaken several measures in that regard.

Dr LUKWAGO (Uganda), speaking on behalf of the Member States of the African Region, said that noncommunicable disease incidence was reaching epidemic proportions in many countries. The burden of disease disproportionately affected poor and disadvantaged populations and was expected to increase by 24% in Africa in the coming years if no action were taken. He recognized the multisectoral nature of the response, as many of the underlying determinants of noncommunicable diseases lay outside the health sector. It was therefore important to incorporate noncommunicable disease control into all policies and to involve all public and private sectors.

The main areas for control and prevention were: monitoring the diseases and their risk factors through effective surveillance mechanisms; taking action to reduce risk factors; improving health care for those with noncommunicable diseases through health system strengthening; improving funding; raising public awareness; and reducing the high costs of health care, especially in countries with no social protection. Doing that would require increased political commitment by Member States to prioritizing control of noncommunicable diseases and investing more resources in the development and implementation of national plans.

Dr MOHAMED (Oman) questioned whether the diseases under discussion merited the description “noncommunicable”; it seemed to him that they were communicable, as they were transmitted socially between individuals in, for example, the home and school environments.

He commended the Secretariat’s work in his country. Under a recent national programme, persons over the age of 40 years were being advised to undergo tests for diabetes and other noncommunicable diseases in the expectation that vaccines would be developed and introduced over the following decade. Sufficient resources should be devoted to such programmes. WHO had a significant role to play in the forthcoming high-level meeting of the United Nations General Assembly by drawing attention to noncommunicable diseases and to the determining role of behaviour.

He proposed that an additional paragraph should be inserted at the end of the draft resolution to read: “to report to the Sixty-fifth World Health Assembly, through the Executive Board, on the outcomes of the high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases and on progress in implementing this resolution at all levels”.

Mr DESIRAJU (alternate to Mr Chandramouli, India) said that noncommunicable diseases must remain high on national and international agendas. He welcomed United Nations General Assembly’s decision to convene a high-level meeting, and the joint initiative by the Russian Federation and WHO to hold the First Global Ministerial Conference on Noncommunicable Diseases and Healthy Lifestyles in April 2011. The Member States of the South-East Asia Region would also be meeting in Jakarta in March 2011 to discuss the subject.

In India two thirds of all deaths annually were due to noncommunicable diseases, and chronic diseases and injuries were the leading causes of death and disability. He strongly supported the identification in the draft resolution of the four categories of noncommunicable diseases that needed particular focus, but urged inclusion of mental illness as a fifth category. Some 13% of India’s population, or 150 million people, were believed to suffer from mental illness at some point of their lives, and, at any single point in time, about 3.5 million people were thought to be receiving some form of treatment for mental illness. The disabilities caused by mental illness seriously affected the

possibility to enjoy a full and constructive life, a fact that should be clearly recognized during the high-level meeting.

The Conference of the Parties to the WHO Framework Convention on Tobacco Control at its fourth session (Punta del Este, Uruguay, 15–20 November 2010) had declared the need to include the topic of “challenges to tobacco control” in the agenda of the high-level meeting of the United Nations General Assembly.¹ In India and elsewhere in the South-East Asia Region, smokeless tobacco was a major health hazard that affected women in particular, a fact that should be reflected in the draft resolution.

The focus of efforts needed to go beyond prevention and control to cover treatment and care. Noncommunicable diseases were debilitating and could be ruinous to those who were afflicted and their families and burdened their carers; long-term illness often led to poverty. The need for effective, accessible and inexpensive forms of treatment must be understood and underscored in the draft resolution.

Dr DAULAIRE (United States of America) expressed his Government’s strong commitment to raising the profile of noncommunicable diseases as a major global public-health concern, and many of its agencies were involved in prevention, control and research activities, including the recently launched, major new initiative focusing on individuals with multiple concurrent chronic conditions. He was encouraged by the high-level focus on noncommunicable diseases and supported WHO’s leadership in planning for the United Nations high-level meeting. The participation of his Government’s Secretary of Health and Human Services in the Global Ministerial Conference in Moscow further demonstrated his country’s commitment.

He welcomed the fact that General Assembly resolution 64/265 called for the high-level meeting on prevention and control, with a particular focus on developmental and other challenges and on social and economic impacts in developing countries. He supported the view of the previous speaker that mental illness must be highlighted as an important noncommunicable disease.

Tackling noncommunicable diseases faced significant challenges, and needed considerable support from all stakeholders. He concurred with the member for Oman that so-called noncommunicable diseases were in fact socially communicable, and called for strategies to be devised to interrupt the social and economic chain of transmission. He highlighted the enormous damage caused by tobacco use and the importance of the WHO Framework Convention on Tobacco Control. His Government was committed to reducing the toll of tobacco-related disease, disability and death, nationally and around the world, and had recently decided that graphic warnings should be prominently placed on tobacco packaging.

Despite notable successes in identifying the burden of noncommunicable diseases, there was an absence of similar efforts and investment aimed at tackling those issues. Surveillance and evaluation were crucial, but relatively few evidence-based public-health programmes against the diseases existed, especially in low- and middle-income countries. Assessment of the impact on health was also generally lacking. The report could have focused more on specific aspects, such as the lack of capacity to deal with chronic disease and to promote health in low- and middle-income countries. He looked forward to the reports by WHO on its informal dialogues with civil society and the private sector, both of which had significant roles to play in addressing noncommunicable diseases.

He supported the draft resolution, to which he would submit some minor amendments in writing.

Ms BILLINGS (Canada) commended WHO’s leadership in the preparations for the forthcoming high-level meeting on the prevention and control of noncommunicable diseases and the Secretariat’s analysis of the risks for health and development of failing to tackle them. She endorsed the comments

¹ Decision FCTC/COP4(5).

made by the member for Oman in relation to transmission through behaviour, and agreed that the global response should extend beyond the health sector.

Her Government was preparing a consultation in preparation for the meetings in New York and Moscow. In September 2010, federal, provincial and territorial health ministers had adopted a Declaration on Prevention and Promotion, which highlighted the priority of the subject and focused on efforts to curb childhood obesity. Unless trends could be reversed, the current generation of children would have a life expectancy lower than that of their parents. Canada was committed to supporting international efforts in the area and, in November 2010, together with PAHO, had hosted the biennial meeting of PAHO's Conjunto de acciones para la reducción multifactorial de enfermedades no transmisibles (the CARMEN initiative for integrated noncommunicable disease prevention). The meeting had facilitated preparation for the United Nations General Assembly high-level meeting.

She welcomed the draft resolution but, as it had only just been made available, requested that Board members be allowed sufficient time to consider the text and prepare amendments.

Dr JADUE (Chile) welcomed the United Nations General Assembly's decision to hold a high-level meeting on noncommunicable diseases, which would provide an opportunity to make up for the omission of those diseases from the Millennium Development Goals. The outcome document should be focused, emphasizing the social and economic importance of noncommunicable diseases. In Chile, for example, there had been a sharp rise in the prevalence of diabetes, and childhood obesity was widespread. United Nations support was needed for policy formulation and coordination of urgent interventions across a range of sectors in order to establish alliances and ensure the necessary lifestyle and legislative changes. The situation would also require careful coordination between international and nongovernmental organizations for a global intersectoral response, encompassing existing instruments such as those on tobacco control and on diet and physical activity. Adequate resources, technical guidance, leadership and political will would be needed to bring about the necessary changes. The situation at country level was equally complex and touched on primary health care, policies to change behaviour, social customs, economic and environmental factors, monitoring capacity, quality of health care and, in the developing countries, elimination of health inequities. He supported the draft resolution.

Ms TOELUPE (alternate to Mrs Gidlow, Samoa) commended WHO's series of global initiatives since 2000, which had culminated in the United Nations' decision to hold the high-level meeting on noncommunicable diseases, which event gave cause for optimism. For small island States such as Samoa, noncommunicable diseases had become the leading cause of morbidity and mortality in the past decade and their prevention and control had become a priority. However, overseas treatment costs and dialysis were major burdens on health budgets. She expressed appreciation for the support already provided by WHO and donors, and hoped that the consistent calls from developing countries for greater attention to noncommunicable diseases would elicit additional resources. She also looked forward to the development of new indicators as an outcome of the United Nations process.

Implementation at national level of the various resolutions and instruments relating to noncommunicable diseases adopted in the previous decade relied on health professionals in health systems that had limited financial and human resources. Integrated programming also posed challenges, especially when funding came with specific conditions, and a more flexible approach by donors would be appreciated. WHO should support noncommunicable disease surveillance, promoting use of the STEPwise approach to risk factor surveillance, with follow-up of regional initiatives and a focus on capacity-building, and research on the effectiveness of programme implementation.

She supported the draft resolution.

Mr YUSOF (Brunei Darussalam) shared the global concern at the rise in noncommunicable diseases, which was having a direct impact on socioeconomic development. Brunei Darussalam had placed health promotion and healthy lifestyles high on the national health and development agenda. He therefore looked forward to the forthcoming high-level United Nations General Assembly meeting. He expressed appreciation for the preparatory work undertaken by the Secretariat and expected that

the meeting would provide the opportunity to involve and collaborate with sectors beyond health, and would result in a commitment to make concerted efforts to combat noncommunicable diseases. He also looked forward to the Western Pacific regional consultation on the subject in Seoul in March 2011 and the Moscow conference in April 2011.

Dr NARVÁEZ (Ecuador) agreed that noncommunicable diseases were a serious public health threat. In Ecuador, noncommunicable diseases, road traffic injuries, and violence were influenced by numerous social, cultural and environmental factors. They contributed to rises in the rates of morbidity, mortality and avoidable disability, principally among the productive population, and to increased demands on health services. Only a few noncommunicable diseases were covered by public health services, so that around half were treated in the private sector, with economic repercussions for families and adverse effects on development. In an effort to promote urgent and innovative intersectoral policies, the South American countries were working on a new human development model based on healthy lifestyles.

Preparations for the United Nations meeting in September 2011 should include the development of a proposed list of items to be put on the agenda for combating noncommunicable diseases, which should include: community participation in prevention and control activities; the human development model; primary health care approaches; and financing of the global strategy for prevention and control.

Dr PÁVA (alternate to Dr Kökény, Hungary), speaking on behalf of the European Union, indicated that the candidate countries Turkey, Croatia, The former Yugoslav Republic of Macedonia and Iceland, the countries of the Stabilisation and Association Process, potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, and Armenia, Georgia, the Republic of Moldova and Ukraine aligned themselves with her statement. She commended the Director-General's personal commitment to the prevention and control of noncommunicable diseases, which, together with several important WHO initiatives, had contributed to the United Nations General Assembly's decision to hold the forthcoming high-level meeting. The noncommunicable disease epidemic was clearly global, taking its toll in morbidity, mortality and use of resources in all countries. The rapidly increasing burden in developing countries with scarce resources and weak health systems was of particular concern. Monitoring and follow-up of global trends must therefore continue. Strong political commitment was needed to tackle preventable noncommunicable diseases and she called for the promotion of healthy environments and dealing with the broad range of risk factors and determinants of mental and physical health. Countries should share research outcomes and best practices with a view to strengthening national strategies. Health systems, the institutional basis for public health, and primary health care services should all be strengthened with specific capabilities for prevention and control of noncommunicable diseases and adequate financing. A well-developed, competent and accountable primary health care sector could lead preventive programmes and make a valuable contribution to effective control.

The European Union would participate constructively in the preparations for the September high-level meeting, and she urged WHO to do likewise. Strong political leadership and a common, solid platform for action were essential for tackling the key determinants of health, in terms of lifestyles and underlying social and environmental factors, as clearly illustrated in the final report of the Commission on the Social Determinants of Health. The high-level meeting should generate global commitment and momentum to implement the global strategy and action plan for the prevention and control of noncommunicable diseases, and the Director-General should continue her strong support for action in the area, in particular in tackling risk factors, and strengthening health systems and public health functions, through a population-based approach.

Citing Rule 11 of the Rules of Procedure of the Executive Board which required the elapse of 48 hours after the distribution of relevant documents, she requested that consideration of the draft resolution be postponed until Monday 24 January to allow time for consultation. She further expressed concern at the large number of draft resolutions submitted late in the session. Such short notice hindered Board members' ability to give the texts proper consideration and to consult with their capitals.

The CHAIRMAN, endorsing the previous speaker's concern, urged Board members to avoid late submission of draft resolutions at future sessions. In the absence of any objection, he took it that the Board agreed to postpone consideration of the draft resolution on prevention and control of noncommunicable diseases until Monday, 24 January.

It was so agreed.

Dr REN Minghui (China) expressed appreciation for WHO's efforts in the prevention and control of noncommunicable diseases, including the global strategy and action plan, and its work towards the September high-level meeting. The exclusion of noncommunicable diseases from the Millennium Development Goals had been a serious omission, and the Organization had demonstrated leadership in securing the integration of noncommunicable disease indicators in the core monitoring and evaluation system for the Goals.

China's strategy for the prevention and control of those diseases was integrated in its next five-year socioeconomic development plan. Current health reforms and the healthy cities campaign were facilitating the development of low-cost, simple but effective interventions, establishment of surveillance and information systems, and capacity-building for the development of a multisectoral network to encourage greater participation in prevention and control efforts.

The April conference in Moscow and the September high-level meeting at the United Nations should spur prevention and control of noncommunicable diseases. WHO should coordinate the efforts of all stakeholders to ensure the success of the September meeting and implementation of the outcome document. The Secretariat should also define priorities for the global strategy and action plan, and formulate monitoring and evaluation indicators.

He supported the comments made by the member for India. Full implementation of the WHO Framework Convention on Tobacco Control would make an important contribution and should be included in the draft resolution and the agenda of the high-level meeting. He would submit appropriate amendments to the Secretariat.

Professor STARODUBOV (Russian Federation) commended WHO's work in placing noncommunicable diseases on the global health agenda. Urgent, joint measures were needed to tackle the current situation, and the Russian Federation was therefore cosponsoring the draft resolution.

Prevention and control measures required political will, an understanding of their importance by Heads of State, and a common humanitarian approach. His Government was therefore organizing jointly with WHO the First Global Ministerial Conference on Noncommunicable Diseases and Healthy Lifestyles in Moscow in April 2011. He reiterated the invitation to the conference. It should be an important intersectoral event resulting in a declaration that should provide a valuable input to the United Nations high-level meeting. The draft resolution, if it were to be adopted by the Board, might need to be amended at the Health Assembly to take account of the output of the Moscow conference.

Dr MIŠIĆ (alternate to Professor Milosavljević, Serbia) welcomed the timely organization of the Moscow conference and the high-level meeting of the United Nations General Assembly, which should promote a concentrated and coordinated response for preventing and controlling noncommunicable diseases at national, regional and global levels. Prevention required an integrated approach involving all levels, from governments to individuals. Experience in Serbia had shown that such an approach could be translated into action through: establishment of a well-defined strategic network with operational action plans and measurable targets with specific target dates; the building of consensus on the importance of action; sustained financing, political support for national plans; and emphasis on behavioural change. Attention should also be given to reaching vulnerable and marginalized populations. She supported the draft resolution.

Dr ALI (alternate to Professor Haque, Bangladesh) commended WHO's activities in relation to the September high-level meeting and looked forward to the outcome document, which should generate momentum and a commitment to the implementation of the global strategy and action plan

for the prevention and control of noncommunicable diseases. It should also ensure the inclusion of prevention and control activities on the global development agenda and in related investment decisions. As the response extended beyond the health sector, Bangladesh would use the guidance provided to set priorities and allocate resources appropriately in developing an integrated, multisectoral approach. However, it would require further technical support for capacity-building, strengthening of surveillance and basic health infrastructures, development of access to essential information, and health promotion, taking into account the need to ensure a balance between prevention activities and access to affordable diagnosis and treatment. Development partners and donors should develop and implement practical, low-cost solutions using a population-based approach through primary health care systems. Early detection and treatment were vital.

He welcomed the draft resolution, which merited careful consideration.

Dr MAHFOUDI (adviser to Mr El Makkoui, Morocco) recognized the serious challenge noncommunicable diseases posed to health systems and development, which threatened to compromise achievement of the Millennium Development Goals. However, efforts to promote sustainable development, especially in low-income countries, were not yet giving sufficient priority to noncommunicable disease prevention and control. The outcome document from the September high-level meeting should therefore refer to a commitment at the highest level to giving priority to the development of adequately-funded national prevention and control policies, including promotion of healthy lifestyles. Policy-makers should take due account of the socioeconomic impact of noncommunicable diseases, especially on the poorest and most vulnerable groups, and should implement sustained, cross-cutting programmes. The Doha Declaration on Noncommunicable Diseases and Injuries, adopted in May 2009, urged WHO and partners to work together to define global and national objectives. Global indicators on disease levels and risk factors and collection of reliable data were needed to assess progress and facilitate the formulation of appropriate responses. Moreover, international development and nongovernmental organizations should integrate noncommunicable disease prevention and control in their global action and investment plans, and should build partnerships to develop well-funded, sustainable community-based interventions that took into account patient rights.

The draft resolution should request the Director-General to prepare a report on progress in implementing its provisions for consideration by the Board at its 130th session and the Sixty-fifth World Health Assembly.

Mr KÜMMEL (adviser to Dr Seeba, Germany) welcomed the United Nations' commitment to raising awareness of the global public health importance of prevention and control of noncommunicable diseases and the holding of the high-level meeting. Strong health systems designed to meet the challenges of such prevention and control were needed, especially in developing countries that were already trying to cope with a high burden of communicable diseases. The high-level meeting should provide political momentum and commitment to WHO's many activities to combat noncommunicable diseases, including the global strategy and action plan for their prevention and control, which promoted a coordinated and integrated approach.

Dr TAKEI (adviser to Dr Omi, Japan) said that Japan would support the regional and global meetings on prevention and control of noncommunicable diseases scheduled for 2011. The increasing burden of noncommunicable diseases, coupled with a lack of reliable data on those diseases, hindered the development of effective national plans and policies. Promotion of healthy lifestyles and strengthening of health systems would therefore be crucial as part of systematic interventions to prevent and control noncommunicable diseases. Ageing was an underlying factor in the rise of noncommunicable diseases; Japan had experienced a rapidly ageing population over the past decade and was sharing the knowledge gained, and strategies and policies developed, for example through a training programme for public health officials arranged in cooperation with the Regional Office for the Western Pacific. Japan would continue to provide such support to Member States.

Mr LARSEN (Norway) stated that noncommunicable diseases accounted for almost 90% of the disease burden in the European Region and for about 60% of all deaths worldwide. WHO's estimates indicated that noncommunicable disease mortality would continue to rise over the next 10 years, most rapidly in low- and middle-income countries. The perception of those diseases as a global challenge that threatened development was timely. WHO must lead the preparation, implementation and follow-up of the September high-level meeting, while the process must be driven by countries themselves, as an effective response required cross-sectoral action that included appropriate national legislation and regulation. WHO's global strategy provided an excellent framework for the work ahead.

The spread of risk factors for noncommunicable diseases was related to globalization and changing lifestyles. It was influenced by the actions of major multinational companies, which would no doubt prove to be strong opponents in discussions on prevention and control measures. In order to mobilize a broad set of stakeholders, civil society must be involved to the extent possible in activities relating to the United Nations high-level meeting. He agreed with previous speakers that Member States should use the opportunity of that meeting to review and restate their commitments to relevant existing international instruments, such as the WHO Framework Convention on Tobacco Control.

More research and data collection were needed to extend knowledge on the distribution of noncommunicable diseases and their risk factors, especially in low- and middle-income countries. It would thus be useful to improve understanding of those patterns within countries and their links to social determinants of health, including the impact of urbanization.

The Moscow conference should provide significant input to the United Nations high-level meeting. He recognized that the Health Assembly might need to amend the proposed draft resolution in the light of the outcome of the Moscow conference.

Ms CHEDEVILLE-MURRAY (adviser to Professor Houssin, France) emphasized WHO's role in governance, in liaison with other international organizations. The high-level meeting at the General Assembly should serve to identify and clarify the relevant global governance issues. It should also provide the opportunity to obtain a more accurate picture of noncommunicable disease trends worldwide, with a view to defining responses at a time when they were placing an increasingly heavy burden on all countries. Mental illnesses and neurological diseases should be included in that assessment.

Prevention required action on behaviour and risk factors, taking account of economic and social inequalities. Emphasis should be placed on those risk factors relating to the environment, which were all too often overlooked. Progress was needed in areas such as the measurement and prevention of the effects of air pollution on respiratory diseases and the effects of pesticides and phytosanitary and chemical products on cancers and endocrinological diseases.

In terms of response, the exchange of experience and best practices with regard to prevention and treatment should be encouraged with WHO's support. She realized that combating noncommunicable diseases would place a growing strain on the public purse. Her Government therefore favoured an approach that consisted in identifying additional, long-term financial resources, including innovative forms of funding when possible.

Mrs HANJAM DA COSTA SOARES (Timor-Leste), speaking on behalf of the Member States of the South-East Asia Region, recalled resolution WHA53.17, in which the Health Assembly reaffirmed the direction of WHO's global strategy for the prevention and control of noncommunicable diseases. Those actions needed technologically sophisticated treatment, but such treatment was expensive for some developing countries. The morbidity and mortality rates of noncommunicable diseases such as cardiovascular illnesses, chronic obstructive pulmonary disease and diabetes were rising. In its response, Timor-Leste was cooperating with neighbouring countries such as Australia, Indonesia and Singapore. She endorsed the comment made by the member for India that mental illness should also be classified as a priority group of noncommunicable diseases.

Dr GOPEE (Mauritius) said that noncommunicable diseases represented almost 75% of the disease burden in Mauritius. The Director-General's report on the future of financing for WHO

identified “rising public expectations for health care” as one of the factors profoundly shaping WHO’s role.¹ As doctors knew, however, public expectations were more influenced by medical care or treatment than by health care or the promotion and prevention aspects that were – or should be – the main determinants of health for both individuals and the population as a whole. There lay WHO’s fundamental role, reflecting its constitutional definition of health as a state of well-being rather than the absence of disease. The Organization should, therefore, focus much more on health promotion, which should be added as the fourth pillar of the global strategy for the prevention and control of noncommunicable diseases. The report of the Commission on Social Determinants of Health,² which showed the profound impact of non-health factors on health, presented WHO with an opportunity to assume a larger role, in keeping with its own definition of health. Non-health factors were driving the epidemic rise in incidence of noncommunicable diseases in all countries, with the health and economic costs being disproportionately felt by poorer countries.

An answer to the question “What is WHO uniquely well-positioned to do?” was stronger advocacy to governments and political leaders for putting health at the centre of the development agenda. That meant addressing the social determinants of health in their countries by ensuring that the principle of health in all policies was effectively mainstreamed across all sectors. In most countries, non-health ministries and sectors were too busy dealing with issues of direct concern to give due consideration to health. By emphasizing the centrality of health in development at the highest levels, WHO could both fulfil and enhance its core normative role and move towards truly promoting good health, which was surely the best way to stem the rising tide of noncommunicable diseases.

He would submit proposed amendments to the draft resolution in writing to the Secretariat.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland)³ said that the United Kingdom’s health policy had long focused on noncommunicable diseases. Its comprehensive approaches to, *inter alia*, cancer, cardiovascular disease, mental illnesses and diabetes comprised prevention, early intervention and long-term management. Inclusion of the subject on WHO’s wider agenda was therefore logical and welcome. It was to be hoped that a clear and focused role for the Secretariat and Member States would emerge from both the Moscow and the New York meetings.

With the causes of noncommunicable diseases lying in the wider social determinants of health, successful interventions would depend on efforts stretching well beyond the reach of health ministries. Strong links would need to be forged through the World Conference on Social Determinants of Health, due to be held in Rio de Janeiro in October 2011, and the Global Conference on Health Promotion, due to be held in Finland in 2013. Coordination would be required throughout the work resulting from those conferences in order to ensure that the efforts of the Secretariat and Member States were most effectively channelled towards meeting the challenge of noncommunicable diseases.

Mrs BULLINGER (Switzerland)³ said that the forthcoming meetings would assist countries in integrating noncommunicable diseases into national health policies and health systems, even though nongovernmental organizations and civil society would have to be involved, given the scope of the task. The Secretariat should provide before the Moscow interministerial meeting a summary of the various discussions held with civil society. Following that meeting it should be possible to align positions as closely as possible in order to ensure the success of the New York meeting. To that end, he endorsed the draft resolution.

The challenge was to strengthen the preventive and curative aspects of health systems and to integrate noncommunicable diseases into national health policies. His Government had tabled a draft

¹ Document EB128/21.

² 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.

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

law on prevention and health promotion in order to put the fight against noncommunicable diseases on a sound legal footing. Even though Switzerland did not treat noncommunicable diseases as a priority area in its development cooperation work for health, it was active in that field through its prevention and health promotion activities in the context of health system strengthening. It recognized that a substantial effort was still required to respond to what was becoming a genuine health crisis, but the New York meeting should not result in a new vertical funding mechanism, which would directly undermine health systems by distorting national priorities. Rather, existing instruments such as WHO's global strategy for the prevention and control of noncommunicable diseases should be maintained and reinforced.

Dr LAHTINEN (Finland)¹ welcomed the discussion, as the coming years held many important events on the highly important topic. The Eighth Global Conference on Health Promotion, due to be held in Helsinki in June 2013, would build on the previous health promotion conferences with a particular focus on implementation and concrete actions to improve people's health. Together with the Secretariat, Finland would soon contact countries in all WHO regions to request support for the preparatory work, in order to ensure that the Conference was globally significant and relevant for Member States.

The CHAIRMAN requested Board members to submit proposed amendments to the draft resolution to the Secretariat before the end of the day so that a revised text could be prepared.

(For continuation of the discussion, see the summary record of the tenth meeting.)

2. ORGANIZATION OF WORK

The CHAIRMAN recalled that it had been agreed earlier in the session to consider all the progress reports under item 10.2 of the agenda at the same time. He suggested that it might be preferable to consider them in four thematic groups as follows: sections A and B; sections C–E, L and M; sections F–H; and sections J and K.

It was so agreed.

The meeting rose at 12:35.

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

TENTH MEETING

Friday, 21 January 2011, at 14:45

Chairman: Dr M. KÖKÉNY (Hungary)

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

Prevention and control of noncommunicable diseases: Item 4.14 of the Agenda (Document EB128/17) (continued from the ninth meeting, section 1)

Ms QUACOE (Côte d'Ivoire)¹ welcomed the convening of the First Global Ministerial Conference on Noncommunicable Diseases and Healthy Lifestyles in Moscow in April 2011 and the high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases to be held in September 2011. Those meetings should encourage Member States to renew their commitment to tackling noncommunicable diseases and open up new prospects for their prevention and treatment and for alleviating the social and economic burdens they imposed, especially in Africa.

Dr KESKİNKILIÇ (Turkey)¹ emphasized the complexity of the issue and the broad range of challenges to healthy lifestyles. Prevention of noncommunicable diseases required a long-term investment in human resources. In addition, Member States needed to strengthen their health systems and carry out health promotion activities, backed by full government and public support.

Ms RUNDALL (Consumers International), speaking at the invitation of the CHAIRMAN, said that health ministries should take the lead in the development of health policy and its implementation. The notion of actors with commercial interests sharing the tasks of policy-making and governance was worrying and she urged the Secretariat to provide Member States with practical guidance on how to avoid conflicts of interest, especially with regard to the proposed multi-stakeholder forum on global health; they counted on the Secretariat to provide impartial and authoritative advice. Its independence must not be compromised by inappropriate partnerships and funding. The role of industry in the prevention and control of noncommunicable diseases should be more strictly scrutinized. Corporate social responsibility initiatives should be carefully evaluated and not be seen as an alternative to regulation.

Dr COSTEA (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN, stressed WHO's crucial role in the preparations for and follow-up to the United Nations General Assembly's high-level meeting. She supported WHO's emphasis on exclusive breastfeeding and underlined the importance of providing appropriate, nutrient-dense complementary foods to meet the needs of older infants and young children. To combat malnutrition, which contributed to the problem of noncommunicable diseases, the special dietary food industry capitalized on its special expertise in nutrition science in order to ensure that its products were of high quality and met all the applicable standards. Products were enriched with micronutrients adapted to children's special needs. Her organization was willing to contribute its scientific expertise in infant nutrition and product development in order to help organizations and governments to promote nutrition and health.

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

Dr SEYER (The World Medical Association, Inc.), speaking at the invitation of the CHAIRMAN and on behalf of the International Council of Nurses, the International Pharmaceutical Federation, FDI World Dental Federation and the World Confederation for Physical Therapy, which together made up the World Health Professions Alliance, underlined the Secretariat's leadership role, especially in promoting preventive health policies and encouraging Member States to create supportive environments that fostered healthy behavioural choices. Holistic health systems built on a primary health care model, efforts related to the social determinants of health and the involvement of health professionals were essential to tackling the epidemic. The global crisis in human resources in the health sector seriously impeded the reduction of noncommunicable diseases in many countries. Member States were therefore encouraged to strengthen health systems and the health workforce and to draw up strategies for the prevention of noncommunicable diseases in multiple sectors.

Mrs BOURQUIN (World Federation of Public Health Associations), speaking at the invitation of the CHAIRMAN and on behalf of the International Federation of Medical Students Associations and the Global Alcohol Policy Alliance, said that the United Nations General Assembly's high-level meeting would be a major opportunity to stimulate concerted action worldwide on public health and to consolidate political commitment. Only through a public health approach could the world hope to alleviate the heavy burden of noncommunicable diseases. WHO must ensure that the voice of public health professionals was heard at the high-level meeting, during which particular consideration should be paid to the issues of strengthening national public health systems; increasing the number, training and skills of public health workers; and establishing or strengthening national associations of public health professionals.

Dr RALSTON (World Heart Federation), speaking at the invitation of the CHAIRMAN and on behalf of the International Diabetes Federation, the Union for International Cancer Control and the International Union against Tuberculosis and Lung Disease (together making up The NCD Alliance), affirmed that the forthcoming high-level meeting should put noncommunicable diseases firmly on the global agenda, with the potential to increase resources and prevent millions of premature deaths. Noncommunicable diseases were holding back development, and yet, out of the US\$ 22 100 million of official development assistance for health, less than 3% was spent on their prevention and control. She therefore urged Member States: to participate in the consultation process leading up to the high-level meeting in order to ensure that its outcome document contained a specific plan of action, clear targets and accountability mechanisms; to support strong participation of civil society in the meeting, in particular through the establishment of a civil-society taskforce, the inclusion of nongovernmental organizations in Member States' delegations and the appointment of a senior coordinator for the meeting; to encourage Heads of State and Government to attend the meeting so as to ensure the highest level of political support and the world's attention; and to tackle the issue of ensuring equal access to high-quality, affordable medicines in all countries.

Dr BOULYJENKOV (Thalassaemia International Federation), speaking at the invitation of the CHAIRMAN, said that the global burden of noncommunicable diseases, including haemoglobin disorders, continued to increase. Current epidemiological data grossly underestimated the magnitude of the problem worldwide. The Health Assembly had adopted several resolutions on haemoglobin disorders in which it had urged Member States to develop, implement and reinforce comprehensive national programmes for the prevention and management of sickle cell anaemia, thalassaemia and other haemoglobinopathies. Those resolutions facilitated the work of the Federation and supported its activities at country level.

Dr ALWAN (Assistant Director-General) noted that several speakers had referred to WHO's role in advising on cost-effective interventions for noncommunicable diseases. The Secretariat was finalizing evidence-based guidelines on affordable interventions for all countries, to be presented at the First Global Ministerial Conference on Noncommunicable Diseases and Healthy Lifestyles in Moscow in April 2011. In 2008, the Secretariat had set up an epidemiology reference group to

construct a noncommunicable disease surveillance framework encompassing three core components: exposure or risk factors, morbidity and mortality, and health system capacity. Monitoring indicators had been drawn up on the basis of those components. The framework was to be considered at the First Global Ministerial Conference with a view to finalizing guidance for Member States on standardized monitoring that could contribute to the development of a global monitoring system for noncommunicable disease trends and determinants.

The member for Samoa had mentioned the need to support countries in promoting research on prevention of noncommunicable diseases. In implementation of objective four of the action plan for the global strategy for the prevention and control of noncommunicable diseases, the Secretariat had begun working in 2008 with a group of international experts to draw up a prioritized agenda for noncommunicable disease research, focusing on prevention and implementation. The outcomes of three global consultations conducted from 2008 to 2010, which were being published, would be particularly relevant to research on prevention in low- and middle-income countries.

There was no doubt that much higher priority must be accorded to mental health disorders. The Director-General had recently launched the Mental Health Gap Action Programme to provide guidance on expanding interventions. In many countries, up to 75% of people with serious mental disorders had no access to essential health care; health systems must be strengthened to tackle that issue. United Nations General Assembly resolution 64/265 on noncommunicable diseases, building on the action plan for the global strategy, placed emphasis on the four major groups of diseases¹ and the four major risk factors. As the member for India had said, the high-level meeting in September 2011 and the related preparatory events would provide an opportunity to reiterate the calls to action contained in the Mental Health Gap Action Programme.

One of the three components of the action plan and the global strategy was health care. The issues of health system strengthening and financing of noncommunicable disease interventions would be extensively covered at the ministerial conference in April 2011 and would undoubtedly also figure in the outcome paper following the conference.

Responding to a comment by the member from the United States, he said that in 2009 and 2010 the Secretariat had conducted a global survey of national capacities for prevention and control of noncommunicable diseases, focusing on policies and plans, infrastructure and human resources, and essential technologies and medicines. The survey, to which more than 180 Member States had responded, had identified gaps, with particular deficiencies in low- and middle-income States. A report on the results was being prepared and would propose ways of closing the gaps.

The member for Norway had referred to the need for data on noncommunicable disease trends. A report on the global status of noncommunicable diseases, which was to be released imminently, would provide the baseline for future monitoring of regional and country data that provided estimates of key risk factors, including metabolic and physiological, and of mortality. In response to the request by the member for Barbados for countries to be involved in the production of the global status report, he said that a mechanism had been established to ensure that country-related data in the report were validated by Member States. Excellent input had already been received from some countries.

The Board noted the report.

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

¹ Confirmed in resolution 65/238 on the scope, modalities, format and organization of the high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases.

Health system strengthening: Item 4.5 of the Agenda (Documents EB128/8 and EB128/37) (continued from the fifth meeting)

The CHAIRMAN drew attention to a revised version of the draft resolution on sustainable health financing structures and universal coverage that incorporated amendments from Member States, which read:

The Executive Board,
Having considered the reports on health systems strengthening,¹

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

The Sixty-fourth World Health Assembly,
Having considered *The world health report 2010*,² which received strong support from the Ministerial Conference on Health Systems Financing – Key to Universal Coverage (Berlin, November 2010);

PP1 Recalling resolution WHA58.33 on sustainable health financing, universal coverage and social health insurance;

~~PP2 Acknowledging that health and social protection are essential human rights;~~

PP2 Acknowledging the right of everyone to the enjoyment of the highest attainable level of health;

PP3 Recognizing that effective health systems delivering comprehensive health services, including preventive services, are of utmost importance for health, economic development and well-being and that these systems need to be based on equitable and sustainable financing as mentioned in the 2008 WHO Tallinn Charter on “Health systems for health and wealth”;

PP4 Underlining the valuable contribution made by fair and sustainable financing structures, to the achievement of the health-related Millennium Development Goals 4 (Reduce child mortality); 5 (Improve maternal health); 6 (Combat HIV/AIDS, malaria and other diseases); as well as to Goal 1 (Eradicate extreme poverty and hunger);

PP5 Having considered *The world health report 2008*,³ and resolution WHA62.12 that highlighted universal coverage as one of the four key pillars of primary health care through patient-centred care, inclusive leadership and health in all policies;

PP6 Noting that health-financing structures in many countries need to be further developed **and supported** in order to ~~guarantee~~ **expand** access to necessary health **care services** for all while preventing and providing protection against disastrous financial risks;

PP7 Accepting that, irrespective of the source of financing for the health system selected, equitable prepayment and pooling of ~~resources and~~ risks, and the avoidance of, **at the point of delivery, significant direct payments that result in financial catastrophe and impoverishment at the point of delivery**, are basic principles for achieving universal ~~social protection in health~~ **coverage**;

¹ Documents EB128/8 and EB128/37.

² *The world health report 2010. Health systems financing: the path to universal coverage*. Geneva, World Health Organization, 2010.

³ *The world health report 2008. Primary health care: now more than ever*. Geneva, World Health Organization, 2008.

PP8 Reaffirming that, in accepting these basic principles, equity in financing and universal coverage is best realized by risk-pooling at population level, and by ensuring that health care coverage is both comprehensive and affordable;

PP89 Considering that the choice of a health-financing system should be made within the particular context of each country, while the core functions of ~~revenue collection~~, risk pooling, purchasing, and delivery of basic services are important to be regulated and maintained;

PP910 Acknowledging that a number of Member States are pursuing health-financing reforms that may involve a mix of public and private approaches, and a financing mix of contribution-based and tax-financed inputs;

PP4011 Recognizing the important role of state legislative and executive bodies, ~~and with the support of~~ civil society, in further reform of health-financing systems with a view to achieving universal coverage,

1. URGES Member States:¹

(1) to ensure that health-financing systems evolve so as to avoid ~~over-reliance on~~ significant direct payments at the point of delivery, and include a method for prepayment of financial contributions for health care, as well as a mechanism to pool risks among the population in order to avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking the care needed;

(2) to aim for **affordable** universal coverage and access for all **citizens** on the basis of equity and solidarity, so as to provide an adequate scope of health **care** services and level of costs covered, as well as comprehensive and affordable preventive services **through strengthening of equitable and sustainable financial resource budgeting**;

(2)bis to commit to further invest in and strengthen the health-delivery systems, in particular primary health care, adequate human resources for health and health information systems, to ensure that all citizens have equitable access to health care services;

(3) to ensure that external funds for specific health interventions do not distort the attention given to health priorities in the country, that they increasingly comply with the principles of aid effectiveness, and that they contribute in a predictable way to the sustainability of financing;

(4) to plan their health systems transition to universal coverage, while continuing to safeguard the quality of services and to meet the needs of the population in order to reduce poverty and to attain internationally agreed development goals, including the Millennium Development Goals;

(5) to recognize that, when managing the transition to universal coverage, each option will need to be developed within the particular epidemiological, macroeconomic, sociocultural and political context of each country;

(6) to take advantage, where appropriate, of opportunities that exist for collaboration between public and private providers and health-financing organizations, under strong overall government-inclusive stewardship;

(7) to promote the efficiency, transparency and accountability of health-financing **governing** systems;

(8) to ensure that overall resource allocation strikes an appropriate balance between health promotion, disease prevention, **rehabilitation** and health-care provision;

¹ And regional economic integration organizations where appropriate.

- (9) to share experiences and important lessons learnt at the international level for encouraging country efforts, supporting decision-makers, and boosting reform processes;
- (9)bis to establish and strengthen institutional capacity in order to generate country-level evidence and effective evidence-based policy decision on the design of universal health coverage systems;**
2. REQUESTS the Director-General:
- (1) to provide a report on measures taken and progress made in the implementation of resolution WHA58.33, especially in regard to equitable and sustainable health financing and social protection of health in Member States;
- (1)bis to work closely with other UN organizations, international development partners, foundations, academia and civil society organizations, in fostering efforts towards achieving universal coverage;**
- (2) to prepare a plan of action for WHO to support Member States in realizing universal coverage as envisaged by resolution WHA62.12 and *The world health report 2010*;¹
- (2)bis to prepare an estimate of the number of people covered by a basic health insurance that provides access to basic health services, that estimate being divided by country and WHO region;**
- (3) to provide, in response to requests from Member States, technical support for strengthening capacities and expertise in the development of health-financing systems, particularly equitable prepayment schemes, with a view to achieving universal coverage by providing comprehensive health ~~services~~ **care** for all;
- (4) to facilitate within existing forums continuous sharing of experiences and lessons learnt on social health protection and universal coverage;
- (5) to report back to the Sixty-fifth World Health Assembly and thereafter every three years, through the Executive Board, on the implementation of this resolution, including on outstanding issues raised by Member States during the Sixty-fourth World Health Assembly.

The financial and administrative implications for the Secretariat of the draft resolution, which had been introduced at the Board's fifth meeting, remained unchanged.

Mrs REITENBACH (adviser to Dr Seeba, Germany) said that the purpose of the draft resolution, which built on resolution WHA58.33, was to provide support for follow-up to the recommendations made in *The world health report 2010*, to strengthen mutual accountability for moving towards universal coverage and to encourage Member States to maintain and, where necessary, to increase their response. The revised text incorporated amendments proposed by Japan, Norway, Syrian Arab Republic, Thailand and United States of America. In addition, in the seventh preambular paragraph, the words "of risk" should be deleted and the word "of", before the phrase "at the point of delivery", transposed to follow that phrase. In subparagraph 1(2)bis, the words "to commit to further" should be replaced by "to continue to". Japan, Norway, Serbia and Thailand had joined as cosponsors of the draft resolution.

Ms BILLINGS (Canada) supported the draft resolution, which recognized the importance of sustainable health system financing and universal coverage. To standardize the terminology used throughout the text, the words "health care" in the sixth preambular paragraph and subparagraph 2(3),

¹ *The world health report 2010. Health systems financing: the path to universal coverage*. Geneva, World Health Organization, 2010.

and the words “health care services” in subparagraphs 1(2) and 1(2)bis, should be replaced by the phrase “health care and services”. She also recommended the insertion of the words “as appropriate” after “to commit” in subparagraph 1(2)bis, to reflect the fact that some countries might already have in place adequate health system financing mechanisms.

Mr LARSEN (Norway) recalled the outcome of a conference on health in times of global economic crisis: implications for the WHO European Region (Oslo, 1 and 2 April 2009), namely, a set of 12 key recommendations, which the Regional Committee for Europe had noted in resolution EUR/RC59/R3. One recommendation was that revenue collection should be universal, compulsory and redistributive, that is, the wealthy should pay proportionally more than the poor. The seventh and eighth preambular paragraphs of the draft resolution before the Board set out the basic principles for achieving universal health coverage, namely that risks should be pooled and out-of-pocket expenditure kept to a level that did not reduce access to health services. Norway would have preferred the inclusion of a reference to a prepayment system, an idea reflected in *The world health report 2010*, but it had been impossible to achieve consensus on wording. In view of amendments made to the seventh preambular paragraph, he proposed that the eighth preambular paragraph should be deleted and that the words “at population level” be inserted in the seventh preambular paragraph, after the word “pooling”.

Dr BUSS (Brazil) queried the rationale for the proposed deletion of the original second preambular paragraph; a failure to mention essential human rights in the context of universal health coverage might be seen as a step backwards. He urged that the original version of the second preambular paragraph be retained or, alternatively, that Article 25, paragraph 1, of the Universal Declaration of Human Rights, which proclaimed the rights to health and social protection, should be cited in the draft resolution.

Mr HOHMAN (alternate to Dr Daulaire, United States of America) said that, in the light of the informal discussions held, the best solution would be to replace both the original and new versions of the second preambular paragraph by the full text of Article 25, paragraph 1, of the Universal Declaration on Human Rights, prefaced by the word “Recalling”.

Ms ROSE-ODUYEMI (Office of the Governing Bodies) read out the following wording for the second preambular paragraph: “Recalling Article 25, paragraph 1, of the Universal Declaration of Human Rights, which says that ‘Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.’”

The resolution, as amended, was adopted.¹

The CHAIRMAN drew attention to a revised version of the draft resolution on health workforce strengthening, incorporating amendments proposed by Canada, Hungary and Thailand (seconded by Bangladesh), which read:

The Executive Board,
Having considered the reports on health system strengthening,²

¹ Resolution EB128.R8.

² Documents EB128/8 and EB128/37.

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

The Sixty-fourth World Health Assembly,

PP1 Recalling resolution WHA57.19 on challenges posed by the international migration of health personnel, which, inter alia, urged Member States to develop strategies to mitigate the adverse effects of migration of health personnel and minimize its negative impact on health systems, and to frame and implement policies that could enhance effective retention of health personnel;

PP2 Recalling also resolution WHA59.23 on rapid scaling up of health workforce production, which, inter alia, recognized that shortages of health workers are interfering with efforts to achieve the internationally agreed health-related development goals, including those contained in the Millennium Declaration, and those of WHO's priority programmes;

PP3 Taking note of the WHO Global Code of Practice on the International Recruitment of Health Personnel,¹ which, inter alia, recognized that an adequate and accessible health workforce is fundamental to an integrated and effective health system and for the provision of health services, and that Member States should take measures to **meet their own health personnel needs, i.e. take measures to [Hungary] educate, retain and sustain a health workforce that is appropriate for the specific conditions of each country;**

PP3bis Acknowledging the ongoing development of the WHO policy guidelines on transformative scale-up of nursing and medical education, which is related to the increase in quantity, quality and relevance of the skill-mix of the health workforce in an equitable and efficient manner; [Thailand seconded by Bangladesh]

PP4 Noting with approval recent international calls to action regarding the importance of ensuring scale-up and an equitable distribution of the health workforce globally, regionally and within countries;²

PP5 Recognizing the centrality of human resources for health for the effective operation of health systems as highlighted in *The world health report 2006*,³ and that the health workforce shortages and inefficiencies are also seriously hampering effective implementation of primary health care, as stated in *The world health report 2008*,⁴ and expansion of health service coverage, as described in *The world health report 2010*;⁵

PP6 Deeply concerned that shortages and inadequate distribution of appropriately trained and motivated health workers, and inefficiencies in the ways in which the health workforce is managed and utilized, remain major impediments to the effective functioning of health systems and constitute one of the main bottlenecks to achieving the health-related Millennium Development Goals;

¹ Adopted in resolution WHA63.16.

² Including, but not limited to, *the Kampala Declaration and Agenda for Global Action of March 2008*; the G8 Communiqué of July 2008; *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 High-level Taskforce on Innovative International Financing for Health Systems, 2009; and the *Venice concluding statement on maximising positive synergies between health systems and Global Health Initiatives*, 2009.

³ *The world health report 2006 – Working together for health*; Geneva, World Health Organization, 2006.

⁴ *The world health report 2008. Primary health care: now more than ever*. Geneva, World Health Organization, 2008.

⁵ *The world health report 2010. Health systems financing: the path to universal coverage*. Geneva, World Health Organization, 2010.

PP7 Realizing that increased production and improved retention of health workers, **in particular in rural areas [Thailand seconded by Bangladesh]**, is reliant on **various factors including [Thailand seconded by Bangladesh]** a sufficient and sustainable health financing system, which is to some extent determined by decisions made outside the confines of the health sector, including in international organizations;

~~PP8 Taking into account that disease specific programmes established by nongovernmental organizations, international organizations, development organizations and other relevant organizations working in developing countries, while on balance having a positive effect, may in fact increase the burden on the existing health workforce and contribute to attrition of the health workforce from the public sector; [Hungary]~~

PP9 Observing that insufficient evidence on the effectiveness of health workforce policies and a lack of comprehensive, reliable and up-to-date data, including analytical tools, constitute significant challenges for Member States trying to achieve or maintain a sufficient, sustainable and effective health workforce;

PP10 Concerned that many Member States, particularly those with critical shortages or imbalances of health workers, also lack the governance, technical and managerial capacity to design and implement efficient and effective policy interventions related to scaling up and retaining the health workforce;

PP11 Realizing that a sufficient, efficient and sustainable health workforce is at the heart of robust health systems and a prerequisite for sustainable health improvement;

PP12 Recognizing the division of health responsibilities between national and subnational levels of government that is unique to federated states [Canada],

1. **URGES CALLS upon [Hungary] Member States:**¹

(1) to implement the WHO Global Code of Practice on the International Recruitment of Health Personnel in order that both source and destination countries may derive benefits from the international migration of health personnel and in order to mitigate the negative effects of health worker migration on health systems, particularly in countries with critical health worker shortages;

(2) to prioritize, in the context of the global economic context, public sector spending on health, as appropriate, to ensure that sufficient financial resources are available for the implementation of policies and strategies to scale-up and retain the health workforce, particularly in developing countries, and to recognize it as investment ~~for growth in the health of the population [Thailand seconded by Bangladesh];~~

(3) to **consider developing or maintaining [Hungary] a national health workforce plan as an integral part of a validated national health plan, in accordance with national and subnational responsibilities [Canada] with increased efforts towards effective implementation and monitoring, as appropriate in the national context [Hungary];**

(4) to use **and implement [Hungary] evidence-based findings and strategies, including from the Global Health Workforce Alliance Taskforce on Scaling Up Education and Training, for the successful scaling-up of health worker education and training;**

(4)bis to participate actively in the ongoing work of the WHO policy guidelines on transformative scale-up of nursing and medical education in order to increase the workforce numbers and relevant skill-mix in response to country health needs and health systems context [Thailand seconded by Bangladesh];

¹ And regional economic integration organizations as appropriate.

- (5) to develop strategies and policies to increase the availability of motivated and skilled health workers in remote and rural areas, ~~including the evidence-based~~ **with reference to [Thailand seconded by Bangladesh]** WHO global policy recommendations on increasing access to health workers in remote and rural areas through improved retention of the health workforce;
- (5)bis to introduce the strongly recommended effective intervention for increased retention of health workers in rural areas, in particular: improved living conditions, safe and supportive working environment; outreach support; career development and advancement programmes; supporting professional networks; and social recognition of the dedicated health personnel [Thailand seconded by Bangladesh];**
- (5)ter to facilitate full cooperation by recruiters and employers in the observance of the WHO Global Code of Practice on the International Recruitment of Health Personnel; to maintain and regularly update records of all recruiters authorized by competent authorities; to promote good practice among recruiters; and to encourage the use of recruitment agencies that comply with the guiding principles of the Code [Thailand seconded by Bangladesh];**
- (6) to develop or strengthen in-country capacity for health workforce information systems including the collection, processing and disseminating of information on their health workforce, including, but not limited to, stock, education and training capacity, distribution, migration and expenditures; in order to guide, accelerate and improve country action;
- (7) to work with other sectors [Canada] to generate evidence and introduce effective policy interventions in order [Thailand seconded by Bangladesh]** to address other factors that affect the availability of health workers in rural or remote areas, such as socioeconomic deprivation, geographical barriers and distance, transport and the acceptability of services;
- (7)bis to consider adapting, or revising, fiscal policies so that efforts at scaling up and retaining the health workforce are not hindered [Hungary];**
2. URGES nongovernmental organizations, international organizations, international donor agencies, financial and development institutions and other relevant organizations working in developing countries:
- (1) to align and harmonize, in line with the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, their education, training, recruitment and employment practices with those of the countries in which they are based, in particular national health plans, where available, in order to create synergies and support Member States' efforts at building a sustainable health workforce, strengthen health systems and improving health outcomes;
- (2) to support national long-term strategies and interventions to build and sustain a sufficient and efficient health workforce, including investing in the future health workforce ~~by providing funds for education, training and retention~~ **[Hungary];**
3. REQUESTS the Director-General:
- (1) to continue the implementation of the Global Code of Practice on the International Recruitment of Health Personnel, including, upon request, provision of technical support to Member States in implementing the Global Code;
- (2) to provide leadership at global and regional levels by ~~highlighting solutions and giving visibility to issues~~ **generating evidence and recommending effective interventions to address factors [Thailand seconded by Bangladesh]** that hinder access to health workers; to work closely with partner agencies in the multilateral

system on appropriate measures to support Member States' efforts to maintain or achieve a sufficient, sustainable and effective workforce; and to advocate for this topic to be high on global development and research agendas;

(3) to provide technical support to Member States, upon request, for their efforts to scale-up education and training and improve the retention of the health workforce; including identifying efficient and effective health workforce policies and developing and implementing national health workforce plans;

(4) to support Member States, upon request, to strengthen their capacity for coordination on health workforce issues between Ministries of Health, other Ministries and other relevant stakeholders;

(5) to encourage and support Member States in developing and maintaining a framework for health workforce information systems, in order to accommodate the collection, processing and dissemination of information on their health workforce, including stock, migration, education and training capacity, skill mix, distribution, expenditures, positions and determinants of change;

(6) to encourage Member States to support the ongoing development of the WHO policy guidelines on transformative scale-up of health professional education in order to increase the quantity, quality and relevance of the health workforce, and towards addressing shortages in human resources for health in an equitable and efficient manner;

(7) to promote research relevant for both developing and developed countries on efficient and effective policies and interventions to improve scale-up and retention of the health workforce, with the aim of establishing and maintaining an accessible global evidence base for best practice, and efficient and effective health workforce policies and interventions, including supporting the ~~development and~~ [Canada] strengthening of knowledge centres with the purpose of accommodating translation of evidence and best practice into context-specific policy solutions;

(8) to strengthen capacity within the Secretariat with the purpose of giving sufficient priority to relevant tasks related to the Organization's wider efforts in addressing the global health workforce crisis;

(9) to report on progress in implementing this resolution to the World Health Assembly through the Executive Board, in a manner integrated with the reporting on resolution WHA63.16 on the WHO Global Code of Practice on the International Recruitment of Health Personnel.

The financial and administrative implications for the Secretariat of the draft resolution introduced at the Board's fifth meeting remained unchanged.

Mr LARSEN (Norway) reviewed the amendments set out in the revised version of the draft resolution; at an informal meeting of interested Member States, most had been accepted, with a few additional changes. In preambular paragraph 3bis, the words "nursing and medical" should be replaced by "health professional". A new preambular paragraph was to be inserted after that paragraph, to read: "Recognizing that recruiters and employers are key stakeholders who may contribute to success in the implementation of the WHO Global Code on International Recruitment".

At the start of operative paragraph 1, the words "CALLS UPON" should be deleted and the original wording "URGES" reinstated. In subparagraph 1(1), the word "voluntary" should be inserted before "WHO Global Code". In the first line of subparagraph 1(2), the word "context" should be replaced by "conditions" and at the end of the subparagraph, after the new phrase "in the health of the population", the words "which contributes to social and economic development" should be inserted. In the new subparagraph 1(4)bis, the words "nursing and medical" should be replaced by "health professional". The proposed new subparagraphs 1(5)ter and 1(7)bis should be deleted.

With those changes, Brazil had joined the sponsors of the text.

Dr DAULAIRE (United States of America) suggested that, in subparagraph 1(5)bis, the words “introduce the strongly recommended effective intervention” should be replaced by “implement the relevant recommendations” and that the words “in particular” be replaced by “including”.

Dr VIROJ TANGCHAROENSATHIEN (Thailand)¹ suggested that the words “of Health Personnel” should be appended to the end of the new preambular paragraph now placed after preambular paragraph 3bis, so as to correctly reflect the title of the WHO Global Code.

Mr LARSEN (Norway) accepted the amendment proposed by the member for the United States of America and seconded the amendment from the representative of Thailand.

The resolution, as amended, was adopted.²

The CHAIRMAN drew attention to a revised version of the draft resolution on strengthening national health emergency and disaster management capacities and resilience of health systems proposed by Chile, which read:

The Executive Board,
RECOMMENDS to the Sixty-fourth World Health Assembly the adoption of the following resolution:

The Sixty-fourth World Health Assembly,

PP1 Recalling resolutions WHA58.1 and WHA59.22 on emergency preparedness and response, resolution WHA61.19 on climate change and health, and other World Health Assembly and Regional Committee resolutions and action plans on health security, **the International Health Regulations (2005), as well as on** pandemic preparedness, safe hospitals and other matters related to emergencies and disasters at local, **subnational** and national levels;

PP2 Recalling United Nations’ General Assembly Resolutions 60/195, 61/198, 62/192, 63/216, 64/200 and 64/251, which calls upon Member States to increase efforts to implement the *Hyogo Framework for Action 2005–2015: Building the Resilience of Nations and Communities to Disasters*, to strengthen risk reduction and emergency preparedness measures at all levels, and to encourage the international community and relevant United Nations’ entities to support national efforts aimed at strengthening capacity to prepare for and respond to disasters;

PP3 Reaffirming that countries have responsibility for ensuring the protection of the health, safety and welfare of their people and for ensuring the resilience and self-reliance of the health system, which is critical for minimizing health hazards and vulnerabilities and delivering effective response and recovery in emergencies and disasters;

PP4 Regretting the tragic and enormous loss of life, injuries, disease and disabilities resulting from emergencies, disasters and crises of all descriptions;

PP5 Mindful that emergencies and disasters also result in damage and destruction of hospitals and other health infrastructure, weaken the ability of health systems to deliver health services; and setbacks for health development and the achievement of the Millennium Development Goals;

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

² Resolution EB128.R9.

PP6 Expressing deep concern that continuing poverty, increasing urbanisation and climate change are expected to increase the health risks and impacts of emergencies and disasters on many countries and communities;

PP7 Acknowledging that most action to manage the risks to health from natural, biological, technological and societal hazards, including the immediate emergency response, are provided by local and country level actors across all health disciplines, including mass casualty management, mental health and noncommunicable diseases, communicable diseases, environmental health, maternal and newborn health, reproductive health, nutrition and cross-cutting health issues;

PP8 Recognizing the contribution of other sectors and disciplines to the health and well-being of people at risk of emergencies and disasters, including local government, planners, architects, engineers, emergency services and civil protection, and academia;

PP9 Concerned that country and community capacities to manage major emergencies and disasters are often overwhelmed, and that coordination, communications and logistics are often revealed as the weakest aspects of health emergency management;

PP10 Appreciating that some countries, including those with low income or emerging country development status, have reduced mortality and morbidity in disaster situations due to investment in emergency and disaster risk reduction measures, with the support of local, regional and global partners;

PP11 Recognizing that WHO **plays an important role as a member of the International Strategy for Disaster Reduction system and as the health cluster lead in the framework of humanitarian reform,** and works closely with other members of the international community, such as the United Nations Secretariat of the International Strategy for Disaster Reduction, United Nations Development Programme, UNICEF, UN-OCHA, Red Cross/Red Crescent Movement and nongovernmental organizations, on supporting country capacity development and developing institutional capacities for multisectoral emergency and disaster **risk management, which includes disaster reduction;**

PP12 Building on the International Strategy for Disaster Reduction 2008–2009 World Disaster Reduction eCampaign on Hospitals Safe from Disasters, ~~and~~ the 2010–2011 eCampaign on Disaster Resilient Cities, World Health Day 2008 on Climate Change and Health, World Health Day 2009 on Hospitals Safe in Emergencies and World Health Day 2010 on Urban Health Matters, which have resulted in local, **subnational**, national and global action on reducing risks to health from emergencies and disasters;

PP13 Recognizing that improved health outcomes from emergencies and disasters require urgent additional action at country, regional and global levels to ensure that the local, **subnational** and national health risk reduction and overall response in emergencies and disasters is timely and effective and that health services remain operational when they are most needed, **in this respect bearing in mind that emergencies and disasters affect men and women differently,**

1. URGES Member States:¹

- (1) to strengthen all-hazards health emergency and disaster risk management programmes **(including disaster reduction, emergency preparedness and response)**² as part of national and subnational health systems, **supported by legislation, regulations and other measures,** to improve health outcomes, reduce mortality and morbidity, protect investment in health infrastructure and strengthen

¹ And regional economic integration organizations as appropriate.

² Health emergency and disaster risk management includes all measures to assess risks, proactively reduce risks, prepare for, respond to, and recover from, emergencies, disasters and other crises.

the resilience of the health system and society at large **and mainstream a gender perspective into all phases of these programmes;**

(2) to integrate all-hazards health emergency and disaster risk management programmes **(including disaster reduction)** into National Health Plans and institutionalize capacities for coordinated health and multisectoral action to assess risks, proactively reduce risks, prepare for, respond to, and recover from, emergencies, disasters and other crises;

(3) to develop safe and prepared hospitals programmes which ensure that new hospitals and health facilities are located and built safely to withstand local hazards, that the safety of existing facilities is assessed and remedial action is taken, and that all health facilities are prepared to respond to internal and external emergencies;

(4) to promote regional and subregional collaboration, including sharing of experience and expertise for capacity development, as well as in risk reduction, response and recovery;

(5) to strengthen the role of local health workforce in the health emergency management system to provide local leadership and health services, through enhanced planning, training, and access to other resources;

2. REQUESTS the Director-General:

(1) to ensure WHO at all levels has enhanced capacity and resources, and optimizes its expertise across all disciplines in the Organization, in order to provide the necessary technical guidance and support to Member States and partners, for developing health emergency and disaster risk management programmes at national, **subnational** and local levels;

(2) to strengthen collaboration with **and ensure coherence and complementarity of actions with those of** relevant entities, including public, private, nongovernment and academia to support country and community health emergency and disaster risk management, **which includes disaster reduction, as well as ongoing efforts of Member States to implement the International Health Regulations (2005);**

(3) to strengthen the evidence base for health emergency and disaster risk management, including operational research and economic assessments;

(4) to support national **and subnational** assessments of risks and capacities for health emergency and disaster risk management, as a basis for catalysing action and strengthening national **and subnational** health emergency and disaster risk management capacities, **including disaster reduction;**

(5) to provide a report to the **Sixty-sixth** World Health Assembly through the **132nd session of the** Executive Board on progress made in the fulfilment of this **R**esolution;

3. CALLS UPON **Member States**, donors and development cooperation partners to allocate sufficient resources for health emergency and disaster risk management programmes and partners through international cooperation for development, humanitarian appeals, and support for the World Health Organization's role in all international health related matters.

The financial and administrative implications for the Secretariat of the draft resolution introduced at the Board's fifth meeting remained unchanged.

Ms BILLINGS (Canada) recognized the importance of health emergency and disaster preparedness, response and recovery. In order to reflect the division of national and subnational

responsibilities unique to federated States, she requested the insertion of “or subnational” after “national” in subparagraph 1(2).

Dr ALHAJ HUSSEIN (alternate to Dr Said, Syrian Arab Republic) endorsed the amended draft resolution. International cooperation was especially important in order to better manage disasters and limit their adverse effects.

Dr RASAE (Yemen), supported by Dr BUSS (Brazil) and Professor STARODUBOV (Russian Federation), endorsed the draft resolution, as amended by the member for Canada.

Dr JADUE (Chile) read out the amendments reflected in the revised version of the draft resolution, including the one to subparagraph 1(2) just proposed by Canada. In addition, the word “risk” should be inserted between “disaster” and “reduction”.

The resolution, as amended, was adopted.¹

The CHAIRMAN drew attention to a revised version of the draft resolution on strengthening nursing and midwifery incorporating amendments proposed by Member States, which read:

The Executive Board,
Having considered the reports on health system strengthening,²

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

The Sixty-fourth World Health Assembly,

PP1 Recognizing the need to build sustainable national health systems and to strengthen national capacities to achieve the goal of reduced health inequities;

PP2 Recognizing the crucial contribution of the nursing and midwifery professions to strengthening health systems, for increasing access to comprehensive health services for the people they serve, and to the efforts to achieve the internationally agreed health-related development goals, including the Millennium Development Goals and those of the World Health Organization’s programmes;

PP3 Concerned at the continuing shortage and maldistribution of nurses and midwives in many countries and the impact of this on health care and more widely;

PP4 Acknowledging resolution WHA62.12 on primary health care, including health system strengthening, which called, inter alia, for the renewal and strengthening of primary health care, as well as urging Member States to train and retain adequate numbers of health workers, with appropriate skill mix, including primary care nurses and midwives, in order to redress current shortages of health workers to respond effectively to people’s health needs;

PP4bis Acknowledging the ongoing WHO initiatives on the scaling up of transformative health professional education and training in order to increase the workforce numbers and the relevant skill-mix in response to the country health needs and health systems context;

PP4ter Recognizing the global policy recommendations by WHO on “increasing access to health workers in remote and rural areas through improved

¹ Resolution EB128.R10.

² Documents EB128/8 and EB128/37.

retention” as an evidence platform in developing effective country policies for rural retention of nursing and midwifery personnel;

PP5 Taking note of the WHO Global Code of Practice on the International Recruitment of Health Personnel;¹

PP6 Reaffirming the call for governments and civil society to strengthen capacity to address the urgent need for skilled health workers, particularly midwives, made in the WHO UNFPA UNICEF World Bank Joint Statement on Maternal and Newborn Health;

PP7 Noting the importance of multidisciplinary involvement, including that of nurses and midwives, in high-quality research that grounds health and health systems policy in the best scientific knowledge and evidence, as elaborated in WHO’s strategy on research for health, endorsed in resolution WHA63.21;

PP8 Noting that nurses and midwives form the majority of the workforce in many countries’ health systems, and recognizing that the provision of knowledge-based and skilled health services maximizes physical, psychological, emotional and social well-being for individuals, families and societies;

PP9 Recognizing the fragmentation of health systems, the shortage of human resources for health and the need to improve collaboration in education and practice and primary health care services;

PP10 Having considered the reports on progress in the implementation of resolution WHA59.27 on strengthening nursing and midwifery;²

PP11 Mindful of previous resolutions to strengthen nursing and midwifery (WHA42.27, WHA45.5, WHA47.9, WHA48.8, WHA49.1, WHA54.12 and WHA59.27) and the new strategic directions for nursing and midwifery services in place for the years 2011–2015;³

PP12 Recognizing the need to improve the education of nurses and midwives;

1. URGES Member States to demonstrate their commitment to strengthening nursing and midwifery by:

(1) developing targets and action plans for **the development of** nursing and midwifery, as an integral part of national **or subnational** health plans, that are reviewed regularly in order to respond to population-health needs and **health-system** priorities as appropriate;

(2) forging strong, interdisciplinary health teams to address health and health-system priorities recognizing the distinct contribution of nursing and midwifery knowledge and expertise;

(2)bis participating in the ongoing work of WHO’s initiatives on scaling up transformative education and training in nursing and midwifery in order to increase the workforce numbers and the mix of skills that respond to the country’s health needs and are appropriate to the health system context;

(3) collaborating ~~regionally~~ **within their regions and** with the nursing and midwifery professions in the strengthening of national **or subnational** legislation and ~~of~~ regulatory processes ~~that~~ which govern those professions, including the development of entry-level competencies for the educational and technical preparation of nurses **and midwives; consideration must be given to the development of the continuum of education that is required in order to achieve the required level of expertise of nurse and midwifery researchers;**

¹ Adopted in resolution WHA63.16.

² See documents A61/17 and A63/27.

³ Document WHO/HRH/HPN/10.1.

- (4) harnessing the knowledge and expertise of nursing and midwifery researchers to contribute evidence for health-system innovation and effectiveness;
- (5) ~~engaging actively~~ **actively engage** the expertise of nurses and midwives in the **planning, development, implementation and evaluation** of health and health-system policy and programming;
- (6) implementing strategies for enhancement of inter-professional education and collaborative practice including community health nursing services as part of people-centred care;
- (7) including nurses and midwives in the development and planning of human resources programmes which support incentives for recruitment, retention and strategies for improving workforce issues, such as remuneration, conditions of employment and development of positive work environments;
- (7)bis introducing the effective interventions proposed in the global policy recommendations on increasing access to health workers in remote and rural areas through improved retention;¹**
- (8) implementing the WHO Global Code of Practice on the International Recruitment of Health Personnel, ~~especially as it relates to health worker migration, given the national impact of the loss of trained nursing staff~~ **given the national impact of the loss of trained nursing staff;**

2. REQUESTS the Director-General:

- (1) to strengthen WHO's capacity for development and implementation of effective nursing and midwifery policies programmes through continued investment and appointment of professional nurses and midwives to specialist posts in the WHO Secretariat both at headquarters and in regional posts;
- (2) to engage actively the knowledge and expertise of the Global Advisory Group on Nursing and Midwifery in key policies and programmes that pertain to health systems, the social determinants of health, health human resources and the Millennium Development Goals;
- (3) to provide technical support and evidence for the development and implementation of policies, strategies and programmes on inter-professional education and collaborative practice and community health nursing services;
- (4) to provide support to Member States in optimizing the contributions of nursing and midwifery to meeting national health policies and the internationally agreed health-related development goals, including those contained in the Millennium Declaration;
- (5) to encourage the involvement of nurses and midwives in the integrated planning of human resources for health, particularly with respect to strategies for maintaining adequate numbers of competent nurses and midwives;
- ~~(6) to keep the World Health Assembly informed of progress made with the implementation of this resolution, and to report, through the Executive Board, to the World Health Assembly in 2012 and 2014.~~
- (6) to report on progress in implementing this resolution to the World Health Assembly, through the Executive Board, in a manner integrated with the reporting on resolution WHA59.27 on strengthening nursing and midwifery.**

¹ *Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations*. Geneva, World Health Organization, 2010.

The financial and administrative implications for the Secretariat of the draft resolution introduced at the Board's fifth meeting remained unchanged.

Dr BIRINTANYA (Burundi) said that, as the reporting requirements set out in resolution WHA59.27 had come to an end in 2010, the final phrase in subparagraph 2(6) of the draft resolution, "in a manner integrated with the reporting on resolution WHA59.27 on strengthening nursing and midwifery", should be deleted.

Dr DAULAIRE (United States of America) said that the subparagraph had been proposed by his delegation in an effort to consolidate some of the reporting requirements faced by the Director-General. He had not been aware that any reporting requirements under WHA59.27 had ceased and requested clarification on that point.

Mr SOLOMON (Office of the Legal Counsel) confirmed that the reporting requirements mentioned in subparagraph 2(6) had ended in 2010.

The resolution, as amended, was adopted.¹

The CHAIRMAN drew attention to a revised version of a draft resolution on strengthening national policy dialogue to build more robust health policies, strategies and plans, incorporating amendments proposed by Canada. The financial and administrative implications for the Secretariat, which remained unchanged, had been introduced during the fifth meeting. The revised text read:

The Executive Board,

Having considered the report on health system strengthening: improving support to policy dialogue around national health policies, strategies and plans,²

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

The Sixty-fourth World Health Assembly,

PP1 Having considered the importance of policy directions suggested by the world health reports for 2008 and 2010;^{3,4} resolution WHA62.12 on primary health care, including health systems strengthening; resolutions EUR/RC60/R5 on addressing key public health and health policy challenges in Europe: moving forwards in the quest for better health in the WHO European Region; WPR/RC61.R2 on the Western Pacific Regional Strategy for health systems based on the values of primary health care; AFR/RC60/R1 on a strategy for addressing key determinants of health in the African Region and documents AFR/RC60/7 on health systems strengthening: improving district health service delivery, and community ownership and participation and SEA/RC63/9 on development of national health plans and strategies;

PP2 Recognizing that robust and realistic national health policies, strategies and plans are key in strengthening health systems based on primary health care;

¹ Resolution EB128.R11.

² Document EB128/8.

³ *The world health report 2008. Primary health care: now more than ever.* Geneva, World Health Organization, 2008.

⁴ *The world health report 2010. Health systems financing: the path to universal coverage.* Geneva, World Health Organization, 2010.

PP3 Underlining the importance of coherent and balanced policies, strategies and plans under ministries of health vis-à-vis consolidating efforts to reach the Millennium Development Goals;

PP4 Acknowledging that many Member States have made efforts to ensure that their national health policies, strategies and plans respond better to growing expectations for improved health and better services;

PP5 Noting that an inclusive policy dialogue with a comprehensive range of stakeholders, within and beyond government, within the health sector and other health-related activities of other sectors, is critical to increasing the likelihood that national policies, strategies and plans will be appropriately designed and implemented and will yield the expected results,

1. URGES Member States:

- (1) to show effective leadership and ownership of the process of establishing robust national **or subnational** health policies and strategies, basing that process on broad and continuous consultation of relevant stakeholders, within and outside the public sector;
- (2) to base their national **or subnational** health policies, strategies and plans on the overarching goals of universal coverage, people-centred primary care and health in all policies, as well as on a comprehensive, balanced and evidence-based assessment of the country's health and health system challenges;
- (3) to ensure that national **or subnational** health policy, strategies and plans are both ambitious and realistic with respect to available resources and the capacities of staff and institutions, and that they address the entire health sector, public as well as private, as well as the social determinants of health;
- (4) to pre-empt disconnection between the national **or subnational** health policies strategies and plans; the subnational operational plans, disease or life-cycle programmes; and the country's overall development and political agenda;
- (5) to regularly monitor, review and adjust their national **or subnational** health policies, strategies and plans with a view to adjusting them to respond to evolving challenges and opportunities, and to ensure that such reviews involve all relevant stakeholders;

2. CALLS upon development agencies to strengthen adherence to the principles of the Paris Declaration on Aid Effectiveness, of alignment, harmonization, country ownership and managing for results, privileging "joined up" efforts through mechanisms such as the International Health Partnership;

3. REQUESTS the Director-General:

- (1) to renew the Organization's emphasis on its role at country level as a facilitator of inclusive policy dialogue around national health policies, strategies and plans, and to reflect this across the Organization's workplans and operations;
- (2) to ensure national policy dialogue receives continued technical inputs for conducting the planning process, particularly at key moments of formulation and review;
- (3) to use the Organization's leverage to promote effective adherence of development agencies to the principles of the Paris Declaration on Aid Effectiveness, of alignment, harmonization, country ownership and managing for results based on priorities set out in the national health policies, strategies and plans;
- (4) to ensure continuity of support to Member States and assist Member States in ensuring the quality of the technical support they receive;

- (5) to build up the Organization's capacity at all levels for enhanced and integrated support to national policy dialogue around national health policies, strategies and plans;
- (6) to report to the next Executive Board/World Health Assembly on progress made, obstacles faced and results obtained in enhancing support provided to Member States to national policy dialogue around national health policies, strategies and plans.

Mr DESIRAJU (adviser to Mr Chandramouli, India) said that, after informal consultations, he was proposing additional amendments. In the third preambular paragraph, the words "vis-à-vis consolidating efforts to reach the Millennium Development Goals" should be changed to "vis-à-vis efforts to achieve the Millennium Development Goals". In the fifth preambular paragraph, the words "within the health sector and other health-related activities of other sectors" should be replaced by "within the health and other sectors". In subparagraph 1(1), the words "consultation of relevant stakeholders, within and outside the public sector" should be altered to "consultation and engagement of all relevant stakeholders". In subparagraph 1(2), the word "its" should be inserted before "health system challenges". In subparagraph 1(3), the words "both ambitious and realistic" should be altered to "ambitious but realistic". Subparagraph 1(4) should be amended to read: "to ensure that national or subnational health policies, strategies and plans are integrated with subnational operational plans, disease or life-cycle programmes and are linked to the country's overall development and political agenda." In subparagraph 1(5), the words "ensure that such reviews" should be deleted. A new subparagraph 1(5)bis should be inserted, reading: "to strengthen their institutional capacity, as appropriate, in harmonizing and aligning donor programmes with national policies, strategies, priorities and plans." In paragraph 2, the words "and other partners" should be inserted after "development agencies" and the words "privileging "joined-up" efforts" should be replaced with "encouraging efforts". Subparagraphs 3(1) and 3(2) should be combined and amended to create a new subparagraph 3(1), reading: "to renew the Organization's role at country level as a facilitator of inclusive policy dialogue around national health policies, strategies and plans, and to reflect this across the Organization's workplans and operations, and to provide technical inputs for conducting the planning process." Subsequent paragraphs should be renumbered accordingly. In subparagraph 3(3), the phrase "to use the Organization's leverage to promote effective adherence of development agencies to the principles" should be shortened to "to promote the principles". Subparagraph 3(4) should be altered to read: "to assist Member States in their efforts to ensure ownership, quality and coordination of the technical support they receive and to foster cross-country and regional learning and cooperation." In subparagraph 3(5), the words "build up" should be changed to "strengthen", and in subparagraph 3(6), the words "the next Executive Board/World Health Assembly" should be amended to "the Sixty-fifth World Health Assembly". He added that Thailand wished to cosponsor the draft resolution.

Mr HOHMAN (alternate to Dr Daulaire, United States of America) suggested that the words "as appropriate" should be added at the end of the new subparagraph 3(1), and that existing subparagraph 3(6) should specify that the Director-General was to report to the Sixty-fourth World Health Assembly through the Executive Board.

Professor STARODUBOV (Russian Federation) requested clarification of subparagraph 1(4), which, in its current version, was confusing. Was integration intended between national and subnational levels or between strategies, plans, operational activities and programmes?

Mr DESIRAJU (adviser to Mr Chandramouli, India) suggested that the words "or subnational" be deleted from that paragraph to make it clearer.

Ms BILLINGS (Canada) supported that suggestion, adding that the original intention had been to ensure that national policies, strategies and plans were integrated with subnational operational activities.

Dr BUSS (Brazil) requested that his country be added to the list of sponsors.

Mr HOHMAN (alternate to Dr Daulaire, United States of America) suggested that the title of the draft resolution should be shortened to read “Strengthening national policy dialogue to build more robust health policies, strategies and plans”.

The resolution, as amended, was adopted.¹

Malaria: Item 4.11 of the Agenda (Documents EB128/14 and EB128/14 Add.1) (continued from the eighth meeting, section 3)

The CHAIRMAN drew attention to a draft resolution on malaria, incorporating the amendments proposed by Germany, India, Mozambique and United States of America, which read:

The Executive Board,
Having considered the report on malaria,²

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

- The Sixty-fourth World Health Assembly,
PP1 Having considered the report on malaria;
PP2 Recalling resolutions WHA58.2 on malaria control and WHA60.18 that established World Malaria Day;
PP3 Recognizing that increased global and national investments in malaria control have yielded significant results in decreasing the burden of malaria in many countries, and that some countries are moving towards elimination of malaria;
PP4 Aware that recent successes in prevention and control are fragile and can only be maintained with sufficient investment to fund global malaria control efforts fully;
PP5 Realizing that current approaches to malaria prevention and control, when fully implemented in an integrated manner, are highly effective, rapidly make an impact and contribute to stronger health systems and the achievement of the health-related Millennium Development Goals;
PP6 Acknowledging that full expansion of malaria control and prevention activities will need adequately-resourced national programmes functioning within effective health systems that provide for an uninterrupted supply of quality-assured commodities and services;
PP7 Conscious that many countries continue to have unacceptably high burdens of malaria and must rapidly increase prevention and control efforts in order to reach the targets set by the Health Assembly and the internationally agreed health-related goals contained in the United Nations Millennium Declaration;
PP8 Cognizant that strategies need to be reoriented in countries that have reduced their disease burden due to malaria in order to sustain those gains;

¹ Resolution EB128.R12.

² Document EB128/14.

PP9 Mindful that antimalarial prevention and control relies heavily on medicines and insecticides whose utility is continuously threatened by the development of resistance of plasmodia to antimalarial agents and of mosquitoes to insecticides;

PP10 Recognizing that many pharmaceutical manufacturers, particularly in sub-Saharan Africa, have deployed significant efforts to ensure that their products are prequalified by WHO but have been unable to do so, and are thereby denied the opportunity to compete for the manufacture and supply of artemisinin combination therapies and other health products in the midst of increased funding, thus further undermining investment in pharmaceutical innovation in the countries affected [Mozambique];

PP11 Recognizing the resolution adopted at the 18th Roll Back Malaria Board Meeting on ACT Manufacturing in malaria-endemic countries [Mozambique],¹

1. URGES Member States:

- (1) to keep malaria high on the political and development agendas, to advocate strongly for ~~adequate predictable long-term~~ **[Germany]** international financing for malaria control, and to sustain national financial commitments for malaria control in order to accelerate implementation of the policies and strategies recommended by WHO, thereby achieving Target 6.C of Millennium Development Goal 6 and the targets set by the Health Assembly in resolution WHA58.2;
- (2) to undertake comprehensive reviews of malaria programmes as an essential step in developing strategic and operational plans for achieving and maintaining universal access to and coverage with malaria interventions, notably:
 - (a) recommended vector-control operations for all people at risk, and maintenance of effective coverage through well-designed and executed strategies for replacement of long-lasting insecticide-treated bednets and targeted communication about their usage;
 - (b) prompt diagnostic testing of all suspected cases of malaria and effective treatment with artemisinin-based combination therapy of patients with confirmed malaria in both the public and private sectors at all levels of the health system including the community level, and to use the expansion of diagnostic services as an opportunity to strengthen malaria surveillance;
- (3) in order to sustain the advances in malaria control, to take immediate action to combat the major threats, namely:
 - (a) resistance to artemisinin-based medicines, by strengthening regulatory services in the public and private sectors, working to halt the use of monotherapies and substandard medicines not meeting international quality standards, introducing quality assurance mechanisms, and improving supply chain management for all malaria commodities and services;
 - (b) resistance to insecticides, by adopting best practices such as rotation of insecticides used for indoor residual spraying and ~~avoiding the use of~~ **using insecticides approved for indoor residual spraying from insecticide classes other than of [USA] pyrethroid when acceptable alternatives are available insecticides for indoor residual spraying [USA]** in areas where usage of insecticide-treated bednets is high;
- (4) to use the expansion of interventions for malaria prevention and control as an entry point for strengthening health systems, including laboratory services, maternal and child health services at peripheral health facilities, integrated

¹ Resolution RBM/BOM/2010/RES.1 29 [Mozambique].

management of illnesses at the community level, and timely and accurate surveillance;

(5) to maintain core national competencies for malaria control by sustaining a strong cadre of malaria experts, including entomologists, at all levels of the health-care system **where appropriate [Germany]**;

(6) **to establish or review legislation to increase the capacity of national regulatory authorities to provide support to local pharmaceutical manufacturers for increasing the quality of artemisinin combination therapies and other health products [Mozambique]**;

(6bis) **to comply with existing commitments and international regulations on the use of pesticides [Germany]**;

(7) **to increase funding for research and development in malaria prevention, control and treatment [Mozambique]**;

2. CALLS upon the international partners, including international organizations, financing bodies, research institutions, civil society, and the private sector:

(1) to ensure ~~adequate sufficient and predictable~~ **[Germany]** global funding so that the global malaria targets for 2015 can be met and malaria-control efforts can be sustained in order to contribute to attaining the health-related Millennium Development Goals;

(2) to harmonize the provision of support to countries for implementing ~~a single national strategic plan based on~~ **[India]** WHO-recommended policies and strategies **based on local endemicity of the disease [India]**, using commodities that meet international quality standards, in order to secure universal access with vector-control and other prevention measures, diagnostic testing of suspected cases of malaria, and rational treatment of patients with confirmed malaria, as well as timely malaria surveillance systems;

(3) to support initiatives for the discovery and development of new medicines and insecticides to replace those whose usefulness is being lost through resistance, and to support both basic research on innovative tools for control and elimination of malaria (including vaccines) and operational research to overcome constraints limiting the expansion and practical effectiveness of existing interventions;

(4) to collaborate with WHO in order to support countries in accomplishing malaria goals and to progress to elimination;

(5) **to focus on particularly vulnerable populations in high-burden countries, such as tribal people threatened by forest malaria and people in fragile situations [Germany]**;

3. REQUESTS the Director-General:

(1) to support the development and updating of evidence-based norms, standards, policies, guidelines, and strategies for malaria prevention, control and elimination in order to chart a course for reaching the 2015 malaria-related targets set by the Health Assembly and in the Millennium Development Goals and for responding to the rapidly declining burden of malaria;

(2) to monitor global progress in control and elimination of malaria and provide support to Member States in their efforts to collect, validate and analyse data from malaria surveillance systems;

(3) to provide support to countries in defining their human resource needs and strengthening human resource capacity for malaria and vector control at national, district and community levels by revitalizing international training courses and subregional training networks and promoting adequate systems of supervision, mentoring and continuing education;

- (4) to provide support to Member States in identifying new opportunities for malaria control, as well as combating major threats, notably plasmodial resistance to antimalarial agents and mosquito resistance to insecticides, through the development and implementation of the Global Plan for Artemisinin Resistance Containment and a global plan for the prevention and management of insecticide resistance;
- (5) ~~to report to the Sixty-sixth and Sixty-eighth World Health Assemblies in 2013 and 2015, through the Executive Board, on implementation of this resolution.~~ **to provide support for strengthening the capacities of manufacturers of artemisinin combination therapies and other health products in countries endemic for malaria so as to comply with the standards of the WHO prequalification programme [Mozambique];**
- (6) **to provide support, upon request, to National Regulatory Authorities in strengthening their capacity and leadership in Good Manufacturing Practice standards and the WHO prequalification process [Mozambique];**
- (7) **to establish a high-level coordination mechanism with the United Nations Industrial Development Organization and Roll Back Malaria Partnership for advocating infrastructure development and the training of pharmaceutical manufacturers from countries endemic for malaria in order to increase access to artemisinin combination therapies and other health products [Mozambique].**

The CHAIRMAN said that the phrase “to report to the Sixty-sixth and Sixty-eighth World Health Assemblies in 2013 and 2015, through the Executive Board, on implementation of this resolution” in the first part of subparagraph 3(5) should have been moved to the end of the draft resolution as a new subparagraph 3(8).

Dr RASAE (Yemen) expressed full support for the amended text.

Dr REN Minghui (China) said that his delegation had already submitted suggested amendments to the Secretariat, principally with regard to the reference to international quality standards in subparagraph 1(3)(a).

Dr DAULAIRE (United States of America) requested that consideration of the item should be postponed until the following day.

The CHAIRMAN took it that the Board agreed to that request, and asked delegations wishing to propose amendments to the draft resolution to submit them to the Secretariat. A revised version of the text would then be circulated for consideration at the Board’s next meeting.

It was so agreed.

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

Infant and young child nutrition: implementation plan: Item 4.15 of the Agenda (Document EB128/18)

Dr ALI (alternate to Professor Haque, Bangladesh) said that the comprehensive implementation plan outlined in the report should foster synergy between the Secretariat, Member States and interested partners, but that the availability of sufficient funds and relevant technical resources should be assured before its introduction.

The rate of exclusive breastfeeding during the first six months of life remained low in most of the South-East Asia Region. Major obstacles to improving the rate were aggressive marketing of infant-food substitutes, inadequate enforcement of the International Code of Marketing of Breast-milk

Substitutes and unsatisfactory compliance with ILO instruments on maternity protection. Little attention had been given to the development of industrially processed, low-cost complementary foods or to raising awareness and disseminating information on complementary foods among mothers and carers in Member States. Improving maternal nutrition and health, ensuring optimal fetal development, and pursuing a life-course approach to interventions would bring overall benefit infant and young child nutrition. In that regard Bangladesh had developed a strategy and an action plan for its implementation, and had recently revised its maternity benefits to provide six-months' statutory maternity leave, so as to support exclusive breastfeeding in working women.

Dr RASAE (Yemen), speaking on behalf of the Member States of the Eastern Mediterranean Region, highlighted the need for coordination between all levels of the Organization in work on infant and young child nutrition. Despite investment by countries in his Region, in 2009 nearly 20% of children under five years of age were malnourished or undernourished and the trends had worsened with the impact of the global financial crisis, especially in low-income countries. In some parts of the Region, however, the rate was falling and progress was being made towards achieving Millennium Development Goal 4 (Reduce child mortality). The Regional Office had assisted countries in implementing national plans. Proper surveillance mechanisms had been introduced, allowing appropriate development measures to be taken, and the influence of other sectors on nutrition was being assessed. Experience was being shared among countries.

Infant and young child nutrition formed a major component of national health plans. WHO's global strategy on infant and young child feeding was a source of useful guidance in tackling malnutrition in general and the specific problem of obesity in children. Great importance was attached to breastfeeding in the first two years of life, and relevant measures were included in national programmes to promote the practice.

Industry should be involved in the consultation process on the implementation plan in order to ensure that its influence could be channelled positively. In line with recommendations of the Regional Committee for the Eastern Mediterranean to accelerate implementation of the strategy, Yemen had stepped up actions under its five-year national plan, in coordination with the Secretariat. He expressed appreciation for the support given by headquarters and the Regional Office in that regard.

Dr DORO (adviser to Dr Ould Horma, Mauritania), speaking on behalf of the Member States of the African Region, welcomed the outline of the implementation plan. Malnutrition was a multidimensional public health problem, and nutritional deficiencies remained among the principal factors in more than half the morbidity and mortality in Africa, particularly among pregnant women and children under five years of age. Sub-Saharan Africa had the highest proportion of underweight births, leading to increased risk of noncommunicable diseases in adulthood. Only one third of infants were exclusively breastfed for the first six months of life, and two thirds of six- to nine-month olds received breast milk and appropriate complementary foods. Around half of children aged between 20 and 23 months were still breastfed. Such poor nutritional practices contributed to malnutrition among children under five years of age; strong decisions and urgent action were needed. He welcomed the multisectoral approach set out in the implementation plan.

Although the plan's five components were important, mention should also have been made of infant and young child nutrition in the context of HIV/AIDS in which exclusive breastfeeding was particularly important, together with the need to improve knowledge and continue to provide information on the issue.

Implementing and expanding health interventions that had an impact on infant and young child nutrition remained a challenge because of a lack of human and financial resources. The lack of necessary capacity-building among health workers and community partners continued to give cause for concern. He reaffirmed Member States' commitment to improving infant and young child nutrition.

Dr PÁVA (alternate to Dr Kőkény, Hungary) spoke on behalf of the European Union. The candidate countries Turkey, Croatia, The former Yugoslav Republic of Macedonia and Iceland, the

countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, along with Ukraine, the Republic of Moldova, Armenia and Georgia, aligned themselves with her statement. The high quality and integrated nature of the proposed implementation plan made for success, and the wide consultation to be launched in 2011 would further enrich the process. To achieve sustainable results, it was essential to link food and nutrition policies across sectors. The European Union had recently adopted health and food security policies that contained nutritional goals and commitments to increase funding for programmes against malnutrition. Improving infant and young child nutrition further would contribute to achieving a range of international goals. The Secretariat's valuable initiative to develop standards for development and growth had already been adopted by many countries and constituted an important tool for assessing child nutrition and identifying those in need of preventive interventions or treatment.

A mixture of approaches should be followed in defining standards and policy guidelines. The implementation plan should be a guide to all relevant stakeholders. Some of its aspects fell within the remit of WHO; others should be tackled in other forums. The various international processes mentioned in the report, particularly FAO's Committee on World Food Security and the Scaling Up Nutrition initiative, could provide the broader perspective and help to ensure a comprehensive approach to nutrition.

She supported the recommendation to protect and promote breastfeeding, given its proven efficiency in reducing child morbidity and preventing recurrent noncommunicable diseases, and to implement the International Code of Marketing of Breast-milk Substitutes. Particular attention should be placed on nutrition and health of pregnant women and mothers as a precondition for adequate nutrition of infants and young children. Universal access to health services was essential for responses to the double burden of malnutrition, but targeted policies were also needed for vulnerable populations, with specific results-based indicators.

Dr REN Minghui (China) endorsed the summary outline of the implementation plan. In China, child nutrition indicators had already been introduced into national and regional economic, social and development plans, and infant and young child feeding packages had been prepared. Between 2002 and 2009, the proportion of infants breastfed for six months had risen to more than 90%, while serious malnutrition among under-five-year-olds had fallen to less than 2%. The importance of infant and young child nutrition for health and the achievement of the Millennium Development Goals called for the commitment of individual countries and the wider international community. WHO should be more proactive in that regard, particularly in the areas of excessive nutrition, surveillance of anaemia and assessment indicators for health-care services. Core indicators for infant and young child nutrition should be established.

Mrs HANJAM DA COSTA SOARES (Timor-Leste), speaking on behalf of the Member States of the South-East Asia Region, welcomed the report. Despite a range of measures from policy-making to grass-roots level activities with support from agencies such as WFP, her country still struggled to deal with malnutrition of infants and young children, which reached rates of more than 40% in some districts. She requested the Secretariat to continue providing strong support to help the country to tackle the problem.

Mr YUSOF (Brunei Darussalam), underscoring the importance of improving infant and young child nutrition in order to reduce child mortality and incidence of noncommunicable diseases, welcomed the outline of the implementation plan and the consultations proposed for 2011. Surveys in his country showed that exclusive breastfeeding declined dramatically from birth, when it was almost universal, to six months, when it was negligible. Measures to improve breastfeeding rates included prenatal education, the provision of supportive postnatal environments, and the extension of maternity leave from 56 to 105 days as of January 2011. Over the past 15 years, the proportion of underweight children had fallen from 13.5% to 9.7%, but the reduction in the prevalence of overweight in children was less encouraging, and the number of overweight and obese children remained a matter of concern.

The implementation plan would provide guidance in formulating and implementing national food and nutrition policies, and he welcomed WHO guidance and technical assistance in that regard.

Dr TAKEI (adviser to Dr Omi, Japan) supported the outlined implementation plan, which would contribute to accelerating action, particularly in countries where progress had lagged behind. Exclusive breastfeeding was an inexpensive but effective nutritional measure that could contribute to achievement of the Millennium Development Goals, and the global strategy on infant and young child feeding should be adopted at national level. Baby-friendly hospitals should also be supported and expanded.

Dr JADUE (Chile), expressing support for the implementation plan, suggested that the four background papers referred to in the report should be consolidated into one single document, which would enable Member States to prepare their own plans and submit suggestions more promptly. A time frame for the proposed consultations and a process for incorporating suggestions should be set in the near future. The issue should be examined at regional level and by international agencies working together. She further suggested changing the name of the plan to cover not only infancy and young childhood but also gestation, which was when good nutrition should begin. Cooperation between countries with similar characteristics that had made most progress should also be strengthened.

Mr DESIRAJU (adviser to Mr Chandramouli, India) said that resolution WHA63.23 and the global strategy on infant and young child feeding should guide further work on the outlined implementation plan, with particular focus on the principles of protection, promotion and support for breastfeeding; breastfeeding rates must be increased. Although it was a difficult issue, a position should be reached on whether and, if so, how the private sector should participate in consultations, again keeping in mind the stance set out in the global strategy, namely that industry should not be part of the policy-making process. India had progressive legislation on promoting infant and baby foods and preventing their misuse, but its implementation record was not good. It was difficult to take effective action against inappropriate promotion activities, particularly in large and often remote areas of the country where breast-milk substitutes were believed to be desirable.

Dr DAULAIRE (United States of America) welcomed the outline implementation plan, with its recognition of the need to create an enabling policy environment, the opportunities afforded by global initiatives, the importance of intersectoral linkages, the need to support capacity development in Member States, and the critical role of information systems, monitoring and evaluation. Its repeated support for the International Code of Marketing on Breast-milk Substitutes was also welcome. He drew attention to the call issued the previous day by the United States Surgeon General for action to support breastfeeding in his country.

Nevertheless, the plan needed strengthening in several respects. It contained no reference to WHO's recommendations on the marketing of foods and non-alcoholic beverages to children. Although it did recognize the double burden of malnutrition, additional emphasis should be placed on approaches to overnutrition and inappropriate nutrition. Interventions that provide food in areas where overweight was an emerging public health concern must be based on evidence and designed to improve overall health and nutrition. The plan should also recognize the dual burden of overnutrition and malnutrition in the same individual or population, and should link strategies for infant and young child nutrition to those for maternal health and nutrition.

The plan should include action to generate and review evidence to support appropriate and country-specific interventions, in order to harmonize the processes of generating and evaluating evidence. It should also provide more information on the important role of partnerships with national and international private-sector entities and how different agencies and bodies can work with them. He requested details of how the Secretariat's resources would be deployed in providing support under the plan.

Dr MOHAMED (Oman) suggested that the report should have made reference to the statistical information on child growth obtained from the long-term study that WHO had undertaken in six countries. Correlating data on nutrition with growth figures should be straightforward and provide useful information. The implementation plan should emphasize the role of breastfeeding in improving both maternal and child health from an emotional, as well as nutritional, point of view, and its importance in the wake of natural disasters and other emergencies. He echoed the comments of the member for India regarding the difficulty of implementing instruments such as the International Code of Marketing of Breast-milk Substitutes, and suggested that alternative implementation methods, including voluntary and mandatory measures, be considered.

Dr AL BITTAR (adviser to Dr Said, Syrian Arab Republic), endorsing the remarks of previous speakers on the importance of breastfeeding, emphasized the need to take all necessary measures to guarantee proper nutrition for infants and young children. Breastfeeding for the first two years of life could have a significant impact in preventing future diseases. Labour legislation should take account of mothers' right to breastfeed and allow appropriately long periods of maternity leave. He urged all Member States to ensure that their legislation was applied in practice.

Dr ST JOHN (Barbados) outlined measures being taken in her country on infant and young child nutrition, including policies on breastfeeding and the creation of baby-friendly hospitals. She supported the linkage of the outlined implementation plan to existing policy frameworks, especially the global strategy for the prevention and control of noncommunicable diseases. Efforts in her country focused on vulnerable groups, for instance by establishing a food bank to supply weekly hampers for individuals and families infected with and affected by HIV.

Dr MUKUKA (Zambia)¹ approved the outlined plan's recognition of the importance of the multisectoral approach to infant and young child nutrition and of involving donors, civil society and the private sector. Such an approach should significantly improve the nutrition of young children, and had been put in place in Zambia at the national level. She endorsed the emphasis in the plan on continuing to collect evidence and identifying gaps in research.

Increasing the coverage of nutrition interventions would need more financial resources. Nutrition programmes currently received less than 1% of overall development assistance, yet malnutrition was the underlying cause of many deaths of young children. Investing in nutrition would therefore reduce overall public health spending in the long term. She called on international partners to consider aligning plans for development assistance on nutrition activities of recognized effectiveness.

Mr ZEVALLOS AGUILAR (Peru)¹ expressed appreciation for the report. He suggested that the four background papers it mentioned should be made more readily available and must be translated into other languages than English. Proper nutrition represented a clear investment in the future and one of the best means of accelerating progress towards achieving the Millennium Development Goals. The establishment of a comprehensive and effective implementation plan would clearly enhance the nutritional outlook for infants and young children, but it must be linked with existing policy frameworks in order to sharpen its specificity and render its actions more effective. He urged Member States to participate in the process of drawing up the implementation plan by providing national data and sharing experiences with a view to establishing best practices. The process should be as inclusive as possible. Regional consultations were needed on the implementation plan to make it comprehensive. Stakeholders must demonstrate the requisite political will and allocate the human and financial resources needed to make the process a success.

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

Dr LHOTSKA (Consumers International), speaking at the invitation of the CHAIRMAN, expressed concern that the implementation plan had shifted the focus away from breastfeeding and complementary feeding towards nutrition in general. As a result, the notions of protection, promotion and support had disappeared, as had any reference to human rights. The plan focused on the period leading up to 2015, whereas her organization favoured a 10-year timeframe. The suggestion that industry take part from the outset in regional and national consultations on the implementation plan, with no guidance on the management of conflicts of interest, was another point of concern. The role of industry had been set out in the global strategy on infant and young child feeding. If that role were expanded into policy-setting, the effectiveness of recommendations for policy and programme implementation would be compromised from the start.

Ms ARENDT (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, also noted the shift in focus to nutrition in general. A comprehensive plan on nutrition was needed, but she expressed concern that breastfeeding might be neglected. Various scientific studies had demonstrated the positive impact on health and poverty reduction and the cost-effectiveness of interventions involving improved early, exclusive and continued breastfeeding. Health Assembly resolutions on infant and young child nutrition provided clear guidance on the elements on which the implementation plan must be built, including maternity protection, complementary feeding after six months, and training of health professionals. The global strategy on infant and young child feeding defined the obligations and responsibilities of industry, and those rules should be applied by WHO during the consultations on the implementation plan. She asked the Secretariat for reassurance that biannual reports would continue to be issued on infant and young child nutrition, the Baby-Friendly Hospital Initiative and the International Code of Marketing of Breast-milk Substitutes.

Ms ATHERSUCH (MSF International), speaking at the invitation of the CHAIRMAN, said that four areas of the implementation plan needed further elaboration. Emphasis should be placed on the need for national governments, particularly in high-burden countries, to take the lead in the multistakeholder consultation process. In developing their national plans, Member States should give highest priority to interventions that met their most urgent needs. The role of the private sector should be clarified in order to avoid conflicts of interest, with clear separation between consultation and standard setting; policy formulation should be independent of private interest to ensure that policies addressed health needs. Guidelines on the commercialization of nutritional food supplements should be developed.

Dr COSTEA (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN, said that the implementation plan should emphasize: healthy, nutritious diets for mothers before, during and after pregnancy; adequate health care to ensure safe labour and delivery; proper use of breast-milk substitutes where necessary; the need to secure access to drinking-water; reducing micronutrient deficiencies; and educational programmes on foods and feeding practices. References to appropriate complementary feeding, particularly to meet the nutritional needs of infants and young children between 6 and 24 months old, should also be strengthened. He echoed calls for a review by WHO of the effectiveness of policy recommendations aimed at improving nutrition outcomes for infants and young children.

Dr ALWAN (Assistant Director-General) said that all contributions would be taken into account in revising the implementation plan. He agreed with the members for Bangladesh and Yemen on the importance of adequate funding; indeed, one of the main actions in the plan was resource mobilization. The three priorities mentioned by the member for China would receive attention during national and regional consultations. The principles set out in resolution WHA63.23 would be maintained, and the various views expressed on private sector involvement had been noted. The Secretariat would ensure respect for the guidelines on interaction with commercial enterprises and would endeavour to prevent conflicts of interest during the consultation process. As requested by several members, the plan would make specific reference to the needs of vulnerable groups, backed by

a careful review of the scientific evidence. He commended the political commitment shown by Member States to protect and promote breastfeeding through actions such as extending maternity leave and making hospitals more baby-friendly.

The plan was intended to improve nutrition from conception to the age of two years. Breastfeeding was by far the most important means of promoting survival and long-term health. He took note of the suggestion made by the member for Chile to include maternal nutrition in the scope and name of the plan and to include information from the background papers in the document to be submitted to the Health Assembly. In response to the comments by the member for the United States of America, he said that the Secretariat had set up a Nutrition Guidance Expert Advisory Group and had established a library of evidence for essential nutrition interventions. Input and guidance on the outline of the plan were welcome; he invited Member States to submit comments through the relevant pages on the WHO web site.¹

The Board took note of the report.

The meeting rose at 17:55.

¹ <http://www.who.int/>.

ELEVENTH MEETING

Saturday, 22 January 2011, at 09:35

Chairman: Dr M. KÖKÉNY (Hungary)

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

Malaria: Item 4.11 of the Agenda (Documents EB128/14 and EB128/14 Add.1) (continued from the tenth meeting)

The CHAIRMAN invited the Board to consider the revised draft resolution on malaria, which incorporated amendments by Member States and which read:

The Executive Board,
Having considered the report on malaria,¹

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

The Sixty-fourth World Health Assembly,

PP1 Having considered the report on malaria;

PP2 Recalling resolutions WHA58.2 on malaria control and WHA60.18 that established World Malaria Day;

PP3 Recognizing that increased global and national investments in malaria control have yielded significant results in decreasing the burden of malaria in many countries, and that some countries are moving towards elimination of malaria;

PP4 Aware that recent successes in prevention and control are fragile and can only be maintained with sufficient investment to fund global malaria control efforts fully;

PP5 Realizing that current approaches to malaria prevention and control, when fully implemented in an integrated manner, are highly effective, rapidly make an impact and contribute to stronger health systems and the achievement of the health-related Millennium Development Goals;

PP6 Acknowledging that full expansion of malaria control and prevention activities will need adequately-resourced national programmes functioning within effective health systems that provide for an uninterrupted supply of quality-assured commodities and services;

PP7 Conscious that many countries continue to have unacceptably high burdens of malaria and must rapidly increase prevention and control efforts in order to reach the targets set by the Health Assembly and the internationally agreed health-related goals contained in the United Nations Millennium Declaration;

PP8 Cognizant that strategies need to be reoriented in countries that have reduced their disease burden due to malaria in order to sustain those gains;

¹ Document EB128/14.

PP9 Mindful that antimalarial prevention and control relies heavily on medicines and insecticides whose utility is continuously threatened by the development of resistance of plasmodia to antimalarial agents and of mosquitoes to insecticides;

~~PP10 Recognizing that many pharmaceutical manufacturers, particularly in sub-Saharan Africa, have deployed significant efforts to ensure that their products are prequalified by WHO but have been unable to do so, and are thereby denied the opportunity to compete for the manufacture and supply of artemisinin combination therapies and other health products in the midst of increased funding, thus further undermining investment in pharmaceutical innovation in the countries affected;~~

PP10 Stressing that WHO and relevant technical partners should identify and address obstacles ~~impeding~~ artemisinin combination therapy (ACT) manufacturers in malaria-endemic countries from achieving prequalification;

PP11 Recognizing the resolution adopted at the 18th Roll Back Malaria Board Meeting on ACT Manufacturing in malaria-endemic countries,¹

1. URGES Member States:

- (1) to keep malaria high on the political and development agendas, to advocate strongly for **adequate and predictable long-term** ~~international~~ financing for malaria control, and to sustain national financial commitments for malaria control in order to accelerate implementation of the policies and strategies recommended by WHO, thereby achieving Target 6.C of Millennium Development Goal 6 and the targets set by the Health Assembly in resolution WHA58.2;
- (2) to undertake comprehensive reviews of malaria programmes as an essential step in developing strategic and operational plans for achieving and maintaining universal access to and coverage with malaria interventions, notably:
 - (a) recommended vector-control operations for all people at risk, and maintenance of effective coverage through well-designed and executed strategies for replacement of long-lasting insecticide-treated bednets and targeted communication about their usage;
 - (b) prompt diagnostic testing of all suspected cases of malaria and effective treatment with artemisinin-based combination therapy of patients with confirmed **falciparum** malaria in both the public and private sectors at all levels of the health system including the community level, and to use the expansion of diagnostic services as an opportunity to strengthen malaria surveillance;
- (3) in order to sustain the advances in malaria control, to take immediate action to combat the major threats, namely:
 - (a) resistance to artemisinin-based medicines, by strengthening regulatory services in the public and private sectors, working to halt the use of monotherapies and substandard medicines not meeting **WHO prequalification standards or strict national regulatory authority standards** ~~international quality standards~~, introducing quality assurance mechanisms, and improving supply chain management for all malaria commodities and services;
 - (b) resistance to insecticides, by adopting best practices such as rotation of insecticides used for indoor residual spraying and ~~avoiding the use of~~ **insecticides approved for indoor residual spraying from insecticide classes other than** ~~of pyrethroids and compounds sharing cross resistance with pyrethroids when acceptable~~ technically appropriate alternatives

¹ Resolution RBM/BOM/2010/RES.1 29.

are available insecticides for indoor residual spraying in areas where usage of insecticide-treated bednets is high;

(4) to use the expansion of interventions for malaria prevention and control as an entry point for strengthening health systems, including laboratory services, maternal and child health services at peripheral health facilities, integrated management of illnesses at the community level, and timely and accurate surveillance;

(5) to maintain core national competencies for malaria control by sustaining a strong cadre of malaria experts, including entomologists, at all levels of the health-care system **where appropriate**;

~~(6) to establish or review legislation to increase the capacity of national regulatory authorities to provide support to local pharmaceutical manufacturers for increasing the quality of artemisinin combination therapies and other health products;~~

(6) to comply with existing commitments and international regulations on the use of pesticides in particular the Stockholm Convention on Persistent Organic Pollutants (Stockholm, 2004);

(7) to increase funding for research and development in malaria prevention, control and treatment;

2. CALLS upon the international partners, including international organizations, financing bodies, research institutions, civil society, and the private sector:

(1) to ensure **adequate sufficient and predictable** global funding so that the global malaria targets for 2015 can be met and malaria-control efforts can be sustained in order to contribute to attaining the health-related Millennium Development Goals;

(2) to harmonize the provision of support to countries for implementing ~~a single national strategic plan based on~~ WHO-recommended policies and strategies **based on local endemicity of the disease**, using commodities that meet **WHO prequalification standards or strict national regulatory authority standards** ~~international quality standards~~, in order to secure universal access with vector-control and other prevention measures, diagnostic testing of suspected cases of malaria, and rational treatment of patients with confirmed malaria, as well as timely malaria surveillance systems;

(3) to support initiatives for the discovery and development of new medicines and insecticides to replace those whose usefulness is being lost through resistance, and to support both basic research on innovative tools for control and elimination of malaria (including vaccines) and operational research to overcome constraints limiting the expansion and practical effectiveness of existing interventions;

(4) to collaborate with WHO in order to support countries in accomplishing malaria goals and to progress to elimination;

(5) to focus on particularly vulnerable populations in high-burden countries, such as tribal people threatened by forest malaria and people in fragile situations;

(6) to work together to support infrastructure development and the training of the pharmaceutical manufacturers from countries endemic for malaria in order to increase access to cost-competitive artemisinin combination therapies that meet international quality standards;

3. REQUESTS the Director-General:

(1) to support the development and updating of evidence-based norms, standards, policies, guidelines, and strategies for malaria prevention, control and elimination in order to chart a course for reaching the 2015 malaria-related targets

set by the Health Assembly and in the Millennium Development Goals and for responding to the rapidly declining burden of malaria;

(2) to monitor global progress in control and elimination of malaria and provide support to Member States in their efforts to collect, validate and analyse data from malaria surveillance systems;

(3) to provide support to countries in defining their human resource needs and strengthening human resource capacity for malaria and vector control at national, district and community levels by revitalizing international training courses and subregional training networks and promoting adequate systems of supervision, mentoring and continuing education;

(4) to provide support to Member States in identifying new opportunities for malaria control, as well as combating major threats, notably plasmodial resistance to antimalarial agents and mosquito resistance to insecticides, through the development and implementation of the Global Plan for Artemisinin Resistance Containment and a global plan for the prevention and management of insecticide resistance;

(5) ~~to provide support for strengthening the capacities of manufacturers of artemisinin combination therapies and other health products in countries endemic for malaria so as to comply with the standards of the WHO prequalification programme~~ to promote transfer of technology to manufacturers of artemisinin combination therapies and malaria-endemic countries to strengthen their capacity to meet WHO prequalification standards;

(6) ~~to provide support, upon request, to National Regulatory Authorities in strengthening their capacity and leadership in Good Manufacturing Practice standards and the WHO prequalification process~~ to provide support, upon request, to national regulatory authorities to strengthen their capacity in Good Manufacturing Practice (GMP) and WHO prequalification standards;

(7) ~~to establish a high-level coordination mechanism with the United Nations Industrial Development Organization and Roll Back Malaria Partnership for advocating infrastructure development and the training of pharmaceutical manufacturers from countries endemic for malaria in order to increase access to artemisinin combination therapies and other health products.~~

(7) to report to the Sixty-sixth and Sixty-eighth World Health Assemblies in 2013 and 2015, through the Executive Board, on implementation of this resolution.

Mr HOHMAN (alternate to Dr Daulaire, United States of America) said that the revised version of the draft was acceptable.

Mr HAGE CARMO (alternate to Dr Buss, Brazil) drew attention to a typographical error in paragraph 3(5): the word “and” should be replaced by “in” to read: “... manufacturers of artemisinin combination therapies in malaria-endemic countries”.

The draft resolution, as amended, was adopted.¹

¹ Resolution EB128.R13.

Child injury prevention: Item 4.16 of the Agenda (Documents EB128/19, EB128/19 Add.1 and EB128/19 Add.2)

The CHAIRMAN invited the Board to consider the report on child injury prevention (document EB128/19). A revised version of a draft resolution that had been considered by the Board at its 127th session¹ was contained in document EB128/19 Add.1.

Ms BILLINGS (Canada) suggested the following amendments, which had been agreed with the sponsors of the draft resolution: the fifth preambular paragraph should be amended to read: "... particularly in low- and middle-income countries where there exists a significant burden of child injuries", and in paragraph 1(3), the word "development" should be replaced by "child development". She further proposed that paragraphs 1(10) and 1(10)*bis* should be combined, to read: "to define priorities for research, taking into consideration the WHO/UNICEF *World report on child injury prevention*,² and work closely with research and development communities, including relevant manufacturers and distributors of safety products".

Dr PÁVA (alternate to Dr Kökény, Hungary), speaking on behalf of the Member States of the European Union, said that the candidate countries Turkey, Croatia, The former Yugoslav Republic of Macedonia and Iceland, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, as well as Ukraine, Republic of Moldova, Armenia and Georgia aligned themselves with her statement. The European Union was alarmed by the fact that globally an estimated 830 000 children under the age of 18 years died every year as the result of unintentional and often avoidable injuries. Most child injuries occurred in low-income and middle-income countries, but in high-income countries they also caused significant problems, accounting for 40% of all child deaths. Although the European Council and the Regional Committee for Europe had placed injury prevention high on national policy agendas,³ the subject was often neglected in public and child health programmes. Prevention of child injuries was an important factor in the achievement of Millennium Development Goal 4 (Reduce child mortality), and should be integrated into a multisectoral approach, including the transport, environment, education, sports and other sectors.

The *World report on child injury prevention* offered Member States a wide range of policy options, and the European Union Child Safety Report Cards and the Europe Summary Report Card rated countries on their adoption, implementation and enforcement of more than 100 proven and effective child injury prevention strategies. With the aid of such resources, all countries could develop comprehensive intersectoral child injury prevention programmes or improve existing ones.

She welcomed the draft resolution, but said that the new version of paragraphs 1(3) and 1(5) limited its scope unjustifiably by confining it to public health programmes. A multisectoral approach was needed, and she therefore suggested the following amendments: paragraph 1(3) should be amended to read "... ensure that funding mechanisms for relevant programmes, including health programmes, cover child injury and prevention ... treatment and rehabilitation and social services". Paragraph 1(4) should be amended to read: "to implement, according to national needs, the key strategies ...". Paragraph 1(5) should be amended to read: "to integrate child injury prevention in national child development programmes and other relevant programmes ...". Paragraph 1(7) should be amended to read: "... a multisectoral policy and plan of action, where necessary, that contain realistic targets ...". The original wording of paragraph 1(8), as submitted to the Board at its 127th session, should be retained.

¹ See document EB127/2010/REC/1, summary record of the second meeting, sections 1 and 5.

² Peden M et al., eds. *World report on child injury prevention*. Geneva, World Health Organization, 2008.

³ Council Recommendation of 31 May 2007 on the prevention of injury and the promotion of safety (2007/C 164/01) and resolution EUR/RC55/R9, respectively.

The Secretariat should seek funding for the implementation of the resolution, and work should not begin until it was clear how it would be financed.

Dr GEDEON (Seychelles), speaking on behalf of the Member States of the African Region, underlined the relevance of child injury prevention to Africa, which had the highest unintentional injury and death rates among children in the world. He welcomed the recommendation for a multisectoral approach. The Member States of the Region were committed to tackling child injuries as an integral part of ongoing child health initiatives.

The definition of a “child” as a person aged up to 20 years, used in the *World report on child injury prevention*, should be included in the Secretariat’s report and footnoted in the draft resolution. The draft resolution should also include a statement encouraging Member States to integrate interventions for preventing child injury into health initiatives for children under five years of age and for adolescents, in order to foster the integration and sustainability of interventions. Tackling child injuries must be at the heart of all initiatives to reduce morbidity and mortality among children and promote general well-being. The huge investment in immunization, nutrition and other child survival programmes risked being wasted if those children went on to suffer injuries later. WHO should promote integration of interventions with existing programmes at country level in order to avoid fragmentation of effort.

Dr REN Minghui (China) said that injury prevention must be part of comprehensive governmental planning. International organizations, Member States, nongovernmental organizations and other stakeholders should establish a mechanism for the exchange of information and coordination of their activities. Families, schools, manufacturers of equipment for children and those responsible for children’s play areas must be made more aware of the importance of prevention. The Secretariat should coordinate actions and seek to have prevention of child injuries included in the targets for Millennium Development Goal 4. He had submitted to the Secretariat several amendments to the draft resolution in writing and supported its adoption.

Dr ST JOHN (Barbados) proposed two amendments to the draft resolution, intended to ensure that small island developing States in the Caribbean could benefit more fully from its provisions: in both the fifth preambular paragraph and paragraph 6*bis*, the word “developing” should be inserted before “low- and middle-income countries”.

Dr DAULAIRE (United States of America) appreciated the emphasis on the need to prioritize and fund prevention activities through appropriate legislative, administrative, social, infrastructural and educational measures. He supported the recommendations and best practices presented in the *World report on child injury prevention*, which he urged Member States to adopt. Reliable global data should be collected on the burden and costs of such injuries, including those to adolescents, many of whom were entering the formal workforce; many data systems greatly underestimated the burden of injury, because many injured children were not treated in government health facilities and were therefore not included in official statistics. Child injury prevention should be integrated into public health and child survival programmes and action plans, including appropriate legislation and regulation, public education and improved emergency and rehabilitation capacity, should be developed. Greater investment was needed in programmatic activities and applied research in low- and middle-income countries. Injury prevention should be part of each country’s planning for the health and well-being of children and adolescents, and would be essential for the achievement of the Millennium Development Goals. Children’s health should also be protected through comprehensive trauma response, emergency and hospital care, and rehabilitation systems. Health ministries should work closely with nongovernmental and research organizations in order to identify, adapt, implement and evaluate appropriate prevention programmes for the most common child injuries.

He proposed the following amendments to the draft resolution: in the fourth preambular paragraph, the phrase “and in International Labour Organization Convention 182 (1999)”¹ should be inserted after “Convention on the Rights of the Child (1989)”; in paragraph 1(7), the phrase “child labour and legal adolescent employment” should be inserted before “product safety”; and in paragraph 1(11), the word “employers” should be inserted before “and relevant professional groups”, and the phrase “workplace hazards” should be inserted before “water and fire hazards”.

Dr SHUKLA (adviser to Mr Chandramouli, India) observed that injuries varied according to the child’s age and environment. In urban areas, many children were injured in road traffic crashes, while in rural areas many children drowned. In India, many children were vulnerable to injuries or assault while working: for instance, children working as ragpickers often suffered cuts or needlestick injuries.

Prevention required multisectoral coordination. The health sector could play a major role in prevention, management and rehabilitation and in the development of injury prevention and control programmes. It could, for instance, provide appropriate prehospital emergency-care programmes and adequate physical, technical and human resources at all levels of health-care delivery; develop cost-effective, culture-specific and sustainable rehabilitation programmes; improve the trauma-care skills of health professionals in order to avoid delays and inappropriate referrals; and establish networks with relevant sectors in order to develop an intersectoral approach. He supported the draft resolution.

Professor AZAD (adviser to Professor Haque, Bangladesh) supported the revised draft resolution. Child injury was a national tragedy in Bangladesh, with an estimated 30 000 children aged under 18 years dying every year. The Ministry of Health and Family Welfare was developing an injury prevention strategy with technical support from WHO and UNICEF, and prevention activities had been included in the next five-year health sector programme. Extending emergency medical services was a priority in a collaborative programme between the Secretariat and his Government.

Developing countries needed support to quantify the economic impact of child injuries on families and the country as a whole, so that country-specific programmes could be prepared. In many countries it was difficult to bring together different sectors, such as transport, health, law, education and environment, to pursue the common goal of injury prevention. Possible areas for intervention and collaboration between sectors should be identified and feasible interventions designed for both the public and the private sectors.

Drowning was a major cause of injury and death among children aged 1–4 years in Bangladesh. His Government had developed simple and cost-effective prevention programmes, and had significant experience in both research and interventions, which it would share with other countries. However, it had yet to develop effective interventions for the prevention of burns. He called on the Secretariat to disseminate the experiences of other countries in that area.

Mr YUSOF (Brunei Darussalam) said that the protection of children against injury required a holistic approach. His Government was endeavouring to prevent child injury through a rights-based approach that linked child welfare with the rights of the child and with social responsibility by means of legislation. Doctors were legally obliged to report suspected cases of child abuse, and maternal and child health personnel worked closely with medical social workers to identify at-risk children and families and direct them to the appropriate agencies for assistance. Thanks to those efforts, child death from injury was a rarity. He supported the draft resolution as amended.

Dr AL BITTAR (adviser to Dr Said, Syrian Arab Republic), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that strategies for the prevention of child injuries did

¹ Convention concerning the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour.

not always take into account the living conditions of children in low- and middle-income countries. Children in such countries were often not adequately protected from injury, and when they were injured, it was difficult and expensive for them to obtain treatment. Injuries suffered by child workers were another major problem. It was important to focus on the social environment and structure in order to create a society safe for children.

The draft resolution put forward an appropriate approach to the prevention of child injuries. Any measures adopted must be consistent with relevant decisions of the United Nations related to unintentional injuries. The Director-General should convene a joint group of relevant organizations in the United Nations system to support low- and middle-income countries in their injury prevention efforts. The Secretariat should support capacity-building to enable all Member States to adopt appropriate interventions at national and international levels and target their investments wisely.

Dr ALWAN (Assistant Director-General), replying to a comment by the member for Bangladesh, said that the Secretariat would publish a document on best practices in burns prevention in the first half of 2011. He thanked Member States and donors for their support of the programme on child injuries, which had achieved a great deal despite its limited funding.

The Board took note of the report.

Pursuant to a request by Ms BILLINGS (Canada), the CHAIRMAN suggested that the Secretariat should prepare a revised version of the draft resolution, incorporating the various amendments, for consideration on Monday 24 January.

It was so agreed.

(For adoption of the draft resolution, see the summary record of the twelfth meeting, section 3.)

United Nations Decade for Action for Road Safety: draft action plan: Item 4.17 of the Agenda (Document EB128/20)

Dr MOHAMED (Oman), welcoming the proclamation of the Decade of Action for Road Safety, said that road traffic injuries were a major problem in the Eastern Mediterranean Region. They hampered the socioeconomic development of countries, as they affected mainly persons of working age. He urged donors to provide the funding required to tackle the problem, especially in the Region, which had the highest rates of death from road traffic injuries in the world, and called on the Secretariat to support capacity-building in Member States for effective action to prevent road traffic injuries.

Dr MAHFOUDI (adviser to Mr Makkoui, Morocco) commended WHO's work in the United Nations Road Safety Collaboration. He welcomed the global status report on road safety, which showed that some countries had no legislation regulating the main risk factors for road traffic injuries. His Government was deeply concerned, particularly since the Eastern Mediterranean Region had the highest number of road traffic injuries in the world, with 50% of those affected being "vulnerable road users". He called upon the Member States of the Region to take action to reduce the principal risk factors for road traffic injuries: failure to use helmets, seatbelts or child restraints; excessive speed; and poor road infrastructure.

He urged the Secretariat to include the following actions in its implementation of the Global Plan for the Decade of Action for Road Safety 2011–2020: improvement of information systems in order to produce accurate and comparable information and to provide a sound basis for the development of national and international interventions; technical support to countries for the exchange of experiences and the establishment of a database so as to determine the magnitude of the problem; and improvement of care and rehabilitation for injured persons through the adoption of appropriate legislation, better training for health workers and capacity-building in trauma care.

Dr GOPEE (Mauritius), speaking on behalf of the Member States of the African Region, said that the Region had one of the highest rates of road traffic fatalities. Road traffic injuries were the fourth leading cause of death among those aged 5–14 years, and it was predicted that, if no action were taken, they would outstrip malaria and HIV/AIDS as the leading cause of death in that age group by 2020. African ministers of transport had recognized the contribution of road safety in the achievement of the Millennium Development Goals, proposing to halve the number of transport-related fatalities by 2015. In 2007, the third African Road Safety Conference had adopted a declaration and a set of recommendations for improving road safety. In response to those recommendations, Mauritius had taken steps, for example, to set up a lead agency on road safety, update and enforce its road traffic legislation, improve road infrastructure, and strengthen prehospital and hospital care. Those measures had helped to reduce road traffic deaths.

Much progress had been made in improving road infrastructure and raising awareness of the issue, but more needed to be done in order to reduce the rate of fatal accidents. Bridging funding gaps and promulgating and enforcing appropriate legislation were some of the actions urgently needed in many countries.

Dr TAKEI (adviser to Dr Omi, Japan) said that road traffic injuries were a major contributor to the global burden of disease and therefore an important public health issue. The decision to make 2011–2020 the Decade of Action for Road Safety and the development of the Global Plan for the Decade were both timely.

In Japan, the number of deaths caused by road traffic injuries had been reduced by two thirds since the 1970s. Multisectoral prevention measures had contributed, with collaboration among all relevant ministries and between the public and the private sectors. Those measures included prevention education in schools, media campaigns, strict traffic regulations, laws requiring use of seatbelts and child seats for children, and, most importantly, measures to prevent driving under the influence of alcohol. Political leadership was crucial, as was strong commitment and a long-term perspective on the issue.

Dr PAVÁ (alternate to Dr Kőkény, Hungary), speaking on behalf of the European Union, the candidate countries Croatia, Iceland, The former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina and Serbia, as well as Armenia, Georgia, the Republic of Moldova and Ukraine, underlined the economic impact of road insecurity, which amounted to between 1% and 3% of gross national product. Road safety needed a comprehensive response, covering multiple sectors. A “health in all policies” approach and the use of health impact assessments in the context of transport policy and town planning were essential means of improving road safety. Adequate investment in public and light transport was particularly important for health, because it enabled mobility and enhanced the safety of more vulnerable road users such as cyclists and pedestrians. The European Union, which supported WHO’s continued work with respect to road safety, had adopted an action plan on urban mobility in 2009 in order to promote synergies between public health and transport policy.

Efforts had been made in the past 10 years to promote road safety as a global policy issue and to formulate specific recommendations for action, moves that had helped to raise awareness of the issue, but greater political will and more funding were needed to deal effectively with a problem of such magnitude. The Global Plan for the Decade of Action for Road Safety provided a framework for long-term coordinated activity to support national and local road safety initiatives. It also provided a time frame for encouraging political and resource commitments both globally and nationally. The Plan’s objectives and targets were realistic and achievable.

Dr REN Minghui (China) commended WHO’s efforts to coordinate activities within the United Nations system to prevent road traffic injuries around the world. His Government endorsed the Decade of Action for Road Safety and keenly awaited the formal launch of the Global Plan for the Decade in May 2011. Road traffic injuries had become the leading cause of death by 2000. Preventing such injuries was the responsibility of various ministries. The most critical determinant of successful action

for road safety was people, including action leaders, road designers, law enforcement agents and road users. All ministries involved should align their policies and coordinate their action. The health sector should not only provide medical treatment but also raise public awareness, working to change unsafe road conduct and collecting and analysing information.

The Secretariat should coordinate the activities of the international community, including the United Nations, to promote the plan widely, organize initiatives on road safety and emphasize the need for governments to show political commitment and the responsibility of various ministries. It should also work with Member States to establish a mechanism for information and communication, the regular sharing of progress reports and the exchange of best practices.

Professor AZAD (adviser to Professor Haque, Bangladesh) said that his country's national road safety action plan entrusted specific responsibilities to several ministries. The Ministry of Health and Family Welfare had developed an injury prevention strategy with the Secretariat's technical support. The strategy emphasized the mandatory use of seatbelts for motor vehicle drivers and passengers and helmets for motorcyclists. Bangladesh had also taken several steps to implement the Global Plan for the Decade of Action for Road Safety 2011–2020, including translation of materials into local languages and formulation of a national plan for the launch in May 2011. Emergency medical services had been strengthened, trauma centres had been opened and prehospital care was being developed.

The common milestones used to measure progress under the Global Plan had to be achievable and sustainable and must take account of resource shortages and high road traffic injury rates in developing countries. A process for sharing of data and experiences should be put in place. Consideration should perhaps be given to setting a regional timeline for implementation of the Global Plan.

Mr NEBENZIA (alternate to Professor Starodubov, Russian Federation) acknowledged the importance of road traffic safety for development. Road traffic deaths and injuries were not only a serious public health problem, but they undermined socioeconomic development and the attainment of the Millennium Development Goals. He therefore welcomed the proclamation of the United Nations Decade of Action for Road Safety and the adoption of the Global Plan and commended the Secretariat's coordinating role.

The Russian Federation had done a great deal to place the issue of road traffic injuries on the international agenda. It had hosted the First Global Ministerial Conference on Road Safety, and had been a cosponsor of the resolution establishing the United Nations Decade of Action for Road Safety. He called upon all Member States to participate actively in the official launch of the Decade in May 2011. Common efforts by countries at the national and international levels would not only save hundreds of thousands of lives, but would contribute to socioeconomic development, particularly in low- and middle-income countries, which would in turn contribute to the achievement of the Millennium Development Goals.

Dr DAULAIRE (United States of America) expressed support for the activities envisaged under the Global Plan for the Decade, including its recommendations for national and international action. The most important players during the Decade of Action would be governments, as facilitators of infrastructural development and maintenance and as regulators of traffic rules, road construction and vehicle safety standards. Through action in those areas, his country had succeeded in almost halving the motor vehicle-related death rate in the past several years. Member States should integrate implementation plans for the Decade of Action into public health and transportation programmes and research, and adopt best practices, especially in low- and middle-income countries, where improved road safety and road traffic injury prevention could make a substantial contribution to economic growth and development by reducing the economic and human costs of road traffic crashes, injuries and deaths.

Mrs HANJAM DA COSTA SOARES (Timor-Leste), speaking on behalf of the Member States of the South-East Asia Region, commended the transparent and comprehensive report. Human

resources were crucial in increasing road safety, which called for strong participation and cooperation at all levels and across all sectors. She supported WHO's role as the coordinating secretariat for implementation of the Global Plan for the Decade and endorsed the Global Plan's focus on activities at national and local level in addition to international action.

Dr SHUKLA (adviser to Mr Chandramouli, India) pointed out that much of the action that needed to be taken in order to prevent road traffic injuries lay outside the purview of the health sector. For instance, it was the responsibility of the highways authorities to make roads safer and that of law enforcement officials to ensure compliance with road safety laws and regulations. A national body should therefore be established in every country at presidential or prime ministerial level to coordinate the activities of all relevant ministries and agencies and to draw up a plan of action.

Mr YUSOF (Brunei Darussalam) said that road traffic injuries were among the top 10 causes of death in his country. A multisectoral road safety council carried out advocacy and education activities on the issue. He welcomed the Global Plan for the Decade of Action and encouraged WHO to take a multisectoral approach to its implementation, involving other sectors and partners in the achievement of its targets.

Dr ALWAN (Assistant Director-General) thanked members for their comments and expressed appreciation to the many Member States' governments that had contributed to the road safety initiative, in particular the Government of Oman, which had played a leading role in raising the issue of road safety within the United Nations, and the Government of the Russian Federation, which had organized the Ministerial Conference. The strengthening of information systems, including data-gathering, the setting and monitoring of targets, and evaluation of progress in Member States were central elements of the Global Plan for the Decade of Action. The Secretariat had launched a web site in order to facilitate the sharing of information on the issue. The national road safety plans developed by Member States would be posted on the site. As requested by the United Nations, WHO would support countries in formulating and implementing their national plans and in monitoring achievements during the Decade by means of indicators and status reports. The Secretariat hoped to mobilize more resources so that it could work with more countries and involve other sectors in the scaling-up of national activities.

The Board took note of the report.

2. STAFFING MATTERS: Item 9 of the Agenda

Statement by the representative of the WHO staff associations: Item 9.4 of the Agenda (Document EB128/INF.DOC/1)

Mr BARRETT (representative of the WHO staff associations) delivered a statement based on the report contained in document EB128/INF.DOC./1, highlighting in particular concerns about the work-life imbalance at WHO and possible ways to restore the balance.

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

3. MATTERS FOR INFORMATION: Item 10 of the Agenda

Reports of advisory bodies: Item 10.1 of the Agenda

Expert committees and study groups (Documents EB128/33 and EB128/33 Add.1)

The Board noted the reports.

Advisory Committee on Health Research (Document EB128/34)

Professor WHITWORTH (Chairman of the Advisory Committee on Health Research) commended the Secretariat's work on implementing the WHO strategy on health research. The strategy had already had a positive impact: many departments were using its guidance to ensure that research priorities matched country's public health needs, and a collaborative group had been set up to improve coordination of research activities. Research was fundamental to ensuring better health; it had provided the foundation, for example, for development of a new meningitis vaccine and a rapid diagnostic tool for multidrug-resistant tuberculosis. Policy based on research and evidence helped to maintain public confidence. Initiatives such as the Global Health Observatory, the eHealth initiatives, the International Clinical Trials Registry Platform and the ethics review system had been vital in ensuring that countries had evidence-based information for their public health needs. She welcomed the decision to make research the key theme of *The world health report 2012*. In view of the frequent difficulty in mobilizing resources for WHO's normative actions, due attention should be paid to the research strategy when determining funding priorities.

The Board noted the report.

Progress reports: Item 10.2 of the Agenda (Documents EB128/35 and EB128/35 Add.1)

The CHAIRMAN suggested that the Board might wish to consider the progress reports in discrete blocks, the first of which contained the two reports on financial matters, followed by those on technical and health matters.

It was so agreed.

- A. The Capital Master Plan (resolution WHA63.7)**
- B. Safety and security of staff and premises (resolution WHA63.6)**

Dr MOHAMED (Oman), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that the Committee had reviewed the reports on the implementation of resolution WHA63.7 on the Capital Master Plan and resolution WHA63.6 on the safety and security of staff and premises.¹ The Committee had recommended that the Board note the two progress reports.

The Board noted the progress reports in document EB128/35.

The CHAIRMAN said that, if he heard no objection, he would take it that the Board wished to consider together the next block of progress reports, which related to communicable diseases and essential medicines (contained in document EB128/35 Add.1).

It was so agreed.

¹ See document EB128/3.

- C. Eradication of poliomyelitis (resolution WHA61.1)**
- D. Prevention and control of influenza pandemics and annual epidemics (resolution WHA56.19)**
- E. Onchocerciasis control through ivermectin distribution (resolution WHA47.32)**
- L. Progress in the rational use of medicines (resolution WHA60.16)**
- M. Implementation by WHO of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors (resolution WHA59.12)**

Dr NARVÁEZ (Ecuador), referring to the progress report on onchocerciasis control through ivermectin distribution, said that the section of the report on the Region of the Americas should be revised to reflect all the progress made in the Region, particularly with regard to treatment coverage, which had surpassed 85%, and cooperation between Brazil and the Bolivarian Republic of Venezuela to reduce transmission of the disease in the Yanomami area of their shared border.

Dr GEDEON (Seychelles), referring to the report on implementing the recommendations of the Global Task Team on Improving AIDS Coordination, said that 38 Member States in the African Region had updated their HIV/AIDS strategic plans, which had led to improved coordination between donors and development partners. Twenty-seven countries had established joint United Nations teams on AIDS. In addition, a Joint United Nations Regional Team on AIDS, bringing together 25 countries in western and central Africa, had been set up to ensure coordinated and efficient support at country and regional levels, resulting in less duplication of work. In some countries, donors were increasing their contributions in support of the joint United Nations teams. Continued support was required from WHO in order to overcome the difficult challenges of coordinating HIV/AIDS efforts.

Dr MOHAMED (Oman) welcomed efforts by Member States to eradicate poliomyelitis, in particular in India and Nigeria. The prevalence of poliomyelitis in certain regions of the world should serve as a warning that greater efforts must be made to prevent new outbreaks; otherwise the work done thus far would be meaningless.

Due attention should be paid to progress in the rational use of medicines. About half the medicines supplied by the health sector were expensive, potentially dangerous and not used in a rational manner. The distribution of medicines should be monitored more closely.

Professor AZAD (adviser to Professor Haque, Bangladesh) said that most Member States in the South-East Asia Region were currently free of poliomyelitis, but remained susceptible to importation of wild poliovirus. In Bangladesh, the last case had been detected in 2006, and national immunization days, with high coverage rates, had been held annually in conjunction with supplementary immunization activities in response to isolation of wild poliovirus in the country or border regions. High-quality surveillance for acute flaccid paralysis was maintained, but, given the risk of importation of cases through increased international travel, eradication needed a combined global effort. Preventing reinfection remained a significant challenge for Member States in the Region, which needed further support in order to maintain a high level of immunity and sustain surveillance. His Government sought guidance on how much longer it would need to conduct periodic risk assessments.

Dr DAULAIRE (United States of America) commended India's substantial progress towards eradicating poliomyelitis and reiterated his country's support for work towards that goal.

With regard to the progress report on the prevention and control of pandemics and annual epidemics of influenza, he said that the pandemic (H1N1) 2009 had highlighted the urgent need to share viruses of pandemic potential, data thereon, and clinical samples, and he welcomed the work of the Global Influenza Surveillance Network. His Government would continue to provide technical support to increase the capacities of developing countries to work in the Network. He acknowledged the work of the Secretariat and regional offices in assessing the disease burden and economic impact of seasonal influenza in countries lacking a seasonal influenza vaccination policy, and commended

those Member States that had established annual vaccination programmes and those that were striving to increase coverage of people at high risk. Increasing and maintaining demand for seasonal influenza vaccines were crucial to sustaining the manufacturing capacity for pandemic influenza vaccines at surge levels. The Secretariat's efforts to increase manufacturing capacity in developing countries were welcome but new sustainable partnerships should be sought. He recorded his country's substantial international support for pandemic preparedness and response.

With regard to the Secretariat's implementation of the recommendations of the Global Task Team on Improving AIDS Coordination among multilateral institutions and international donors, he fully supported efforts by UNAIDS to clarify the roles of its cosponsors in implementing the revised UNAIDS technical support strategy. Besides leading three specific areas, WHO played a unique normative role in the area of HIV/AIDS and the new guidelines that it had issued in 2010 would be incorporated into his country's assistance strategy. He expressed appreciation for the contributions of WHO country offices to the joint United Nations teams on AIDS.

Dr LUKWAGO (Uganda), speaking on behalf of the Member States of the African Region on the progress report on onchocerciasis control through ivermectin distribution, said that WHO should provide guidelines on the elimination of onchocerciasis, ensure the continued availability to countries of ivermectin, and prioritize surveillance efforts. Countries working towards elimination of the disease needed more resources, in particular for community-directed treatment, health education and surveillance, and would appreciate WHO's help in planning and budgeting for elimination efforts. Conflicts in the African Region meant that the vector might be reintroduced in areas that had previously been declared disease free. Another concern was that climate change would lead to the creation of new habitats in which the vector might thrive.

Dr TAKEI (adviser to Dr Omi, Japan) commended the progress made by India and Nigeria towards eradication of poliomyelitis. His Government would continue to support activities towards that goal.

He commended WHO's activities on the rational use of medicines and urged the Secretariat to continue to take the lead. Comprehensive efforts to ensure the rational use of medicines were needed, including implementation of policies to control the safety of medicines and monitor drug resistance, strengthening of health systems, human resource development and dissemination of information. A WHO report on drug resistance would be welcome.

Dr BIRINTANYA (Burundi), referring to the progress report on the prevention and control of influenza pandemics and annual epidemics, said that, as a result of pandemic (H1N1) 2009, the Global Influenza Surveillance Network had been strengthened and the diagnostic capacities of laboratories expanded. Research should be promoted in order to increase the availability of vaccines that provided broader and longer-term immunity and to develop more affordable antiviral medicines.

His country had implemented a series of measures to support the rational use of medicines, including the drawing up of a national essential medicines list; the development of treatment guidelines, in particular for HIV, malaria and tuberculosis; and the establishment of pharmacovigilance systems for monitoring adverse effects and drug resistance. The effectiveness of those measures was nevertheless limited because of the illegal sale of medicines and marketing of counterfeit medicines.

With regard to onchocerciasis control, the community-directed treatment with ivermectin strategy had been the driving force behind many health interventions relating to neglected tropical diseases and it was vital that the international community continue to support those efforts.

Ms BILLINGS (Canada), endorsing the Global Polio Eradication Initiative's Strategic Plan 2010–2012, urged Member States to maintain their support of WHO's poliomyelitis eradication programmes. Her country would continue to provide active technical support in that area. The recently launched Independent Monitoring Board would create a new dynamic in the field of poliomyelitis

eradication by ensuring higher-level involvement in, and more detailed follow-up of, the issues and activities, as well as closer scrutiny of donor countries' involvement.

Dr ST JOHN (Barbados) said that various measures had been implemented in her country to tackle influenza pandemics and epidemics in general, including more training for staff of the newly-established Department of Epidemiology, the launch of a more comprehensive national influenza surveillance system, strengthening of the country's laboratory capacity, and collaboration with regional and international partners to develop new techniques to suppress mosquito breeding sites.

Barbados did not have an essential medicines list, but did have a National Drug Formulary for which the quality, safety, efficacy and cost-effectiveness of medicines were the main selection criteria. In 2009 and 2010, her country had assessed its pharmaceutical situation using WHO's standardized methodology.

With a view to improving coordination of AIDS activities, it had set up a coordinating National HIV/AIDS Commission, although prevention, treatment and care remained the responsibility of the Ministry of Health. In 2010, Barbados had participated in a UNAIDS country-level review of universal access, which had resulted in a decrease in the number of reporting indicators used and the development of new monitoring and reporting strategies.

Professor STARODUBOV (Russian Federation) expressed support for WHO's work on poliomyelitis eradication. His Government had to be extremely vigilant about the possibility of major outbreaks of poliomyelitis in surrounding countries as a recent outbreak in Tajikistan had led to cases in the Russian Federation itself. It was important for the Russian Federation to participate in all global poliomyelitis eradication initiatives and his Government had earmarked funding in 2011 to that end. His country was eager to work with global reference laboratories on developing vaccines against poliomyelitis and offered to share information on experience gained from the recent outbreak in Tajikistan.

Dr MAHFOUDI (adviser to Mr El Makkoui, Morocco) commended WHO's efforts in the sphere of the rational use of medicines but urged full implementation of resolution WHA60.16. In African countries, some medicines were not used in a rational manner because of the difficulty of obtaining them. One solution would be to establish an observatory for monitoring medicines. It was also important to consider the extent to which medicines were prescribed and to prevent people from self-medicating.

Morocco had not detected a case of poliomyelitis for 20 years. However, increasing rates of immigration and numbers of foreign visitors meant that it was possible that cases could be introduced.

Dr DE ASSUNÇÃO OSWALDO SAÍDE (Mozambique), speaking on behalf of the Member States of the African Region, said that the outbreak of poliomyelitis in the Democratic Republic of the Congo in 2010 had highlighted the susceptibility of the Region to resurgence of the disease. Transmission of wild poliovirus was continuing as a result of insufficient supplementary immunization activities. To tackle that problem, supplementary immunization campaigns had been conducted in 2010 in 19 western and central African countries targeting children under the age of five years. The main challenges that remained were inadequate financial resources and shortage of appropriate vaccines.

Dr AL BITTAR (adviser to Dr Said, Syrian Arab Republic) stressed the importance of the eradication of poliomyelitis.

Despite the existence of national essential medicines lists, ensuring the rational use of medicines was increasingly problematic. Some medicines, such as antibiotics, were being sold without prescription, allowing people to self-medicate, and that could have a serious impact on public health. He welcomed the idea of a global observatory suggested by the member for Morocco.

Dr WATT (United Kingdom of Great Britain and Northern Ireland)¹ said that 2011 would be a pivotal year for poliomyelitis eradication and demonstrate whether the progress made in 2010 would continue. Poliomyelitis could be eradicated only with commitment to strengthen routine immunization and sustained political support worldwide. The funding gap remained a major obstacle and she requested more information on the Secretariat's strategy to fill it. One possibility would be to combine expansion of the funding base with mechanisms to protect core activities in case of a shortfall.

She commended the work of the African Programme for Onchocerciasis Control in the poorest and most rural areas. Implementation of that programme in conjunction with other measures such as vitamin-A treatment, management of lymphatic filariasis, use of insecticide-treated bednets, and home management of malaria had been particularly successful. It was important for other disease-specific and primary health care programmes to learn from that experience and to recognize that the community-based approach should complement primary health care services rather than replace them.

Dr NAKATANI (Assistant Director-General), responding to the comments on onchocerciasis control through ivermectin distribution, said that the African Programme for Onchocerciasis Control was in the process of developing a new plan for control of the disease and assured members that the Secretariat would continue to support the Programme and related country activities. In response to the member for Ecuador, he said that the report on onchocerciasis control would be revised to reflect the progress made in the Region of the Americas.

On the issue of improving AIDS coordination, he agreed that it was important to harmonize efforts and increase efficiency in order to provide maximum support to affected countries. That aim was reflected in WHO's existing strategy on HIV, and comments by members would be taken into account during revision of the strategy.

Dr AYLWARD (Global Polio Eradication Initiative) recalled that the Board's comments on the eradication of poliomyelitis made the previous year had been incorporated into the Strategic Plan 2010–2012. The dramatic drop in the number of cases in India and Nigeria, from 1100 in 2009 to just 60 in 2010, had enormous implications for international spread of the disease, as every re-infected country was combating a virus that originated from one of those countries. The establishment of the Independent Monitoring Board had indeed created a new dynamic in poliomyelitis eradication. It had been working with health ministers in countries with "re-established poliovirus transmission" on the development of emergency plans. It was focusing attention on a standardized mechanism to assess the risk of the disease spreading to areas free of poliomyelitis, and was considering how it could be involved in high-level fundraising. Much of the progress in improving vaccine supply was due to the introduction of a bivalent oral poliovirus vaccine in 2010, which had had a greater impact than expected against type 3 virus infection. Four new manufacturers had been prequalified, a figure that was expected to rise to eight over the coming months; supply, therefore, would not be a problem. A two-part strategy had been developed to bridge the funding gap of the Global Polio Eradication Initiative. Efforts would be made to improve the cost-efficiency of the Initiative and reduce its overall budget. Four main methods would be used to obtain greater external funding: encouraging G8 countries to increase their contributions to past levels; involving G20 and Gulf Cooperation Council countries; using innovative funding mechanisms; and focusing on domestic funding.

Dr FUKUDA (Assistant Director-General), responding to comments on the prevention and control of influenza pandemics and annual epidemics, said that the recent pandemic had highlighted global strengths and weaknesses in the handling of pandemic influenza. Both global and national responses clearly depended on good information, and it was vital to have in place global standards and information networks, such as the International Health Regulations (2005) and the Global Influenza Surveillance Network. Furthermore, efforts to prevent and control influenza fundamentally depended

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

on approaches to seasonal influenza. Many countries were developing national policies, but progress often relied on information about the burden of influenza, which was not always readily available. It appeared that the burden of influenza was the same in both developing and developed countries, namely that it had a disproportionate impact on children and elderly people. Efforts to prevent and control influenza also depended on expansion of vaccine production capacity, especially in developing countries, and on equitable access to key materials, such as vaccines and antiviral agents.

Dr HOGERZEIL (Essential medicines and pharmaceutical policies), speaking on the rational use of medicines, acknowledged the requests by the members for Morocco, Oman and the Syrian Arab Republic for increased monitoring of the use of medicines. A global database on the rational use of medicines already existed, but the establishment of national observatories was certainly a good idea. He agreed with the member for Japan that national strategies had to be comprehensive. Adequate information and clinical guidelines for prescribers should be developed, with emphasis on safety reporting, pharmacovigilance and reporting of adverse drug reactions.

(For continuation of the discussion, see the summary record of the twelfth meeting, section 4.)

The meeting rose at 12:40.

TWELFTH MEETING

Monday, 24 January 2011, at 09:10

Chairman: Dr M. KÖKÉNY (Hungary)

1. MANAGEMENT MATTERS: Item 8 of the Agenda (continued)

Election of the Director-General of the World Health Organization: Item 8.1 of the Agenda (Document EB128/27) (continued from the third meeting, section 2)

The CHAIRMAN recalled that, at the third meeting, the Board had established a drafting group, chaired by Dr Mohamed (Oman), to consider the item further.

Dr MOHAMED (Oman), speaking as chairman of the drafting group, said that it had held three meetings, each lasting three hours. It had examined document EB128/27 as well as the proposed draft resolution and draft decision, with a view to preparing a single revised draft resolution. After the first meeting, he had prepared at the request of the drafting group a merged text, which was considered paragraph by paragraph during the second meeting, at which there had been extensive discussion and proposals of further amendments. At the third meeting the Permanent Representative of Algeria had submitted a compromise text that was accepted by the drafting group as a basis for discussion. Some further amendments had been proposed but, thanks to the spirit of cooperation shown by all the participants and the valuable contribution from the representative of Algeria, it had been possible to achieve consensus. The drafting group was therefore proposing a draft resolution on the election of the Director-General of the World Health Organization, which read:

The Executive Board,

PP1 Guided by the Purposes and Principles of the Charter of the United Nations, inter alia article 101, para 3;

PP2 Having regard to the Constitution of the World Health Organization including article 31;

PP3 Reaffirming the continued relevance of the criteria which should be met by the candidate for the post of Director-General, as adopted by the Executive Board in its resolution EB97.R10;

PP4 Recognizing the importance of further strengthening transparency, fairness and equity among Member States of the six regions of the World Health Organization in the process and method of nomination and appointment of the Director-General of the Organization;

PP5 Acknowledging that successful candidates for the post of the Director-General can come from any region but that candidates appointed for this post have so far only come from three out of the six regions of the Organization;

PP6 Recognizing that due regard should be paid to the importance of recruiting future Directors-General on as wide a geographical basis as possible from Member States of the six regions of the World Health Organization;

PP7 Having considered the report by the Secretariat contained in document EB128/27 and taking into account document EB 122/17,

1. DECIDES to establish a time-bound and results-oriented working group on the process and methods of the election of the Director-General of the World Health Organization, open to all Member States;¹
2. REQUESTS the Director-General to convene the working group as soon as possible and to facilitate its work;
3. DECIDES that the working group will examine the following matters with a view to enhancing fairness, transparency and equity among the Member States of the six regions of the World Health Organization with respect to the process of nomination and appointment of the Director-General of the World Health Organization:
 - (1) to review and analyse all the aspects of the nomination and appointment process of the Director-General;
 - (2) to identify, in light of current concerns of a significant number of Member States relating to the nomination and appointment process and methods, the rules, procedures and/or steps which could be either revised, enhanced and/or added to improve the transparency, fairness and equity of the election of the Director-General with a view, inter alia, to ensuring that the recruitment of this Official be in harmony with the provisions of article 101, para 3 of the United Nations Charter;
 - (3) to make specific recommendations on the above;
4. DECIDES that the working group, in undertaking its work, will take into account all relevant WHO and United Nations documentation and resolutions;
5. DECIDES that the working group shall submit an interim progress report to the Sixty-fourth World Health Assembly and a final report, including its recommendations in relation to issues set out in paragraph 3 above, to the 130th session of the Executive Board for final recommendations by the latter to the Sixty-fifth World Health Assembly.

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

1. Resolution Election of the Director-General of the World Health Organization	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected result:
12. To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work.	12.1 Effective leadership and direction of the Organization exercised through enhancement of governance, and the coherence, accountability and synergy of WHO's work.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
Work in support of governance and leadership has implications for all the expected results and indicators for this strategic objective, and for the achievement of all the strategic objectives in the Programme budget.	

¹ And, where applicable, regional economic integration organizations.

3. Budgetary implications

- (a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).**

The Secretariat will need to organize two intergovernmental meetings, each covering a period of five days. The estimated total cost is US\$ 2 million. This figure includes reimbursement of travel costs for one representative from each least developed country, in accordance with resolution WHA50.1.

- (b) Estimated cost for the biennium 2010–2011 (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\$ 1.4 million.

- (c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?**

No.

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

Extrabudgetary sources of funding will be mobilized.

5. Administrative implications

- (a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).**

WHO headquarters.

- (b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.**

Not entirely. No additional costs are anticipated for the Department of Governing Bodies and External Relations, the Office of the Legal Counsel or the Department of Logistics Support Services. However, existing staff will need to be redeployed, and other activities will have to be deferred as a consequence. Additional staff will be required for the intergovernmental meetings (see below).

- (c) 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).**

Conference staff will need to be recruited before, during and after the meetings. The figures mentioned above include the cost of recruitment.

- (d) Time frames (indicate broad time frames for implementation of activities).**

The resolution establishes a time-bound and results-oriented working group of Member States on the process and methods of the election of the Director-General. The working group will submit an interim progress report to the Sixty-fourth World Health Assembly; a final report will be submitted, through the Executive Board, to the Sixty-fifth World Health Assembly.

Implementation therefore covers the 16-month period until the Sixty-fifth World Health Assembly.

Mr SAMRI (adviser to Mr El Makkoui, Morocco) paid tribute to the drafting group for its work, and in particular to its chairman. Consensus had been reached on a proposed draft resolution, which he supported. However, the draft resolution was only the first step, and it would be important for the working group that it proposed to maintain the positive and constructive approach that had informed the work of the drafting group. The goal was to ensure geographical rotation of the post of

Director-General in a fair and transparent manner. It was to be hoped that regions such as the Eastern Mediterranean Region, from which a Director-General had not yet been appointed, would have their aspirations met in due course. Morocco stood ready to participate in a positive spirit in the work of the proposed working group.

Dr BIRINTANYA (Burundi), speaking on behalf of the Member States of the African Region, welcomed the priority given to the item on the Board's agenda.

He supported the draft resolution, which, although not perfect, was a positive and satisfactory outcome to the intensive discussions and marked the beginning of a methodical analysis of the subject. If the resolution were adopted, the proposed working group should be established rapidly, and he requested the Secretariat to facilitate its work with a view to assuring constructive, balanced discussions. In order to avoid problems in the future, participants should ensure that the fundamental principles underlying the election process were taken into account in the working group's deliberations. The exercise would strengthen the Organization.

Mr DÉKÁNY (adviser to Dr Kökény, Hungary), speaking on behalf of the European Union, welcomed the balanced text. He supported the draft resolution, which provided a good basis for consideration of all possible ways of strengthening the recruitment process. The European Union stood ready to engage constructively in the discussions.

Dr REN Minghui (China) said that the proposed text integrated the ideas expressed by all parties and was balanced and comprehensive. He urged its adoption. The outcome of the proposed working group's deliberations should contribute to the success of future Directors-General and enhance WHO's leadership role in health matters.

Dr DAULAIRE (United States of America) acknowledged the spirit of collaboration and desire to achieve consensus that had pervaded the drafting group's discussion. He supported the resulting draft resolution. The proposed working group should explore ways to enhance the transparency, equity and fairness of the nomination and election process throughout all its stages. The United States would continue to take into account all relevant factors, including regional diversity, when examining the candidatures for the post of Director-General.

Mr NEBENZIA (alternate to Professor Starodubov, Russian Federation) commended the Board's approach to the item, which had avoided the need for extensive debate during the Board's formal meetings and at the Sixty-fourth World Health Assembly. The informal consultations had been conducted in a friendly spirit, and the chairman's contribution made him an ideal candidate for the chairmanship of the proposed working group. He thanked the representative of Algeria for the compromise proposal that had formed the basis of the draft resolution currently before the Board. The Russian Federation stood ready to participate in the proposed working group.

Dr ST JOHN (Barbados) supported the draft resolution. Its adoption would be only the beginning of the process which provided a good basis for the drafting of a valuable outcome document. Barbados wished to participate in the proposed working group.

Mr GRINIUS (adviser to Ms Billings, Canada) expressed the hope that the chairman of the drafting group would be willing to chair the proposed working group. Canada supported the establishment of such a group and stood ready to work towards creating a fairer process by strengthening the principle of geographical diversity in the search for the best qualified candidate from among all six WHO regions. It was in the collective interest to ensure strong and effective leadership for WHO. All Member States had shown a strong commitment to increase the transparency and fairness of the nomination and appointment process for the post of Director-General. Canada looked forward to building on the current momentum and to participating in the proposed working group.

Dr RASAE (Yemen) supported the establishment of the proposed working group and looked forward to participating in its work. He agreed with the member for the Russian Federation that the chairman of the drafting group should be asked to chair the working group. The principle of geographical diversity should be applied in the election of the Director-General. Like the member for Morocco, he hoped that transparency and equity would prevail in that process and that it would not be long before candidates were appointed from those regions that had not yet had that honour.

Dr WARIDA (Egypt)¹ said that, although the draft resolution could be improved, it reflected the consensus on the way forward, and provided a positive starting point for future work. It was to be hoped that the proposed working group would quickly accomplish its task and submit specific recommendations to the Board at its 130th session, particularly on ways to improve the rules and procedures governing the election process. It was essential to ensure that that process was fair, equitable, transparent, and based on as wide a geographical representation as possible, taking into account the fact that candidates appointed to date had come from only three of the six WHO regions. Egypt would work with other Member States in the proposed working group and appoint a competent, fair and unbiased bureau of officers, sparing no efforts to support the group's activities.

Mr JAZAÏRY (Algeria)¹ supported the suggestion that Dr Mohamed should chair the proposed working group. He endorsed the statement made by the member for Burundi. The outcome of the group's deliberations was a good omen for future discussions. The spirit of mutual accommodation and bridge-building that had informed those deliberations should be maintained so that all regions had an equal sense of ownership of the work of WHO and could envisage the possibility of a candidate from their region being appointed to the post of Director-General.

Dr MOHAMED (Oman), speaking as chairman of the informal drafting group, commended the work of all its participants whose desire for success had ensured the final consensus. He recognized that its work was only the start of the process. He expressed gratitude for the suggestion that he should chair the proposed working group, but considered that he would require further training in diplomacy and the ways of the United Nations before taking on such a role. In the meantime he would return to his work of combating real rather than diplomatic viruses.

The CHAIRMAN, thanking the chairman of the drafting group for his sterling efforts and for having also served as an excellent Chairman of the Programme, Budget and Administration Committee of the Executive Board, presented him with a small gift as a token of the Board's appreciation.

He took it that the Board wished to adopt the resolution.

The resolution was adopted.²

2. ORGANIZATION OF WORK

The CHAIRMAN said that informal consultations on the draft resolution on prevention and control of noncommunicable diseases (agenda item 4.14) were continuing, and he therefore suggested that the Board should defer further consideration of the item to a later meeting.

It was so agreed.

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

² Resolution EB128.R14.

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

Child injury prevention: Item 4.16 of the Agenda (Documents EB128/19, EB128/19 Add.1 Rev.1 and EB128/19 Add.2) (continued from the eleventh meeting, section 1)

The CHAIRMAN drew attention to the revised draft resolution on child injury prevention contained in document EB128/19 Add.1 Rev.1, which incorporated the amendments proposed at the eleventh meeting. He reminded the Board that the financial and administrative implications for the Secretariat of the draft resolution were set out in document EB128/19 Add.2.

Dr BUSS (Brazil) requested clarification of the wording of the amendments to subparagraphs 1(7) and 1(11) proposed by the member for the United States of America, which appeared to suggest that child labour was to be regulated. In Brazil, child labour was not permitted.

Dr DAULAIRE (United States of America) assured the member for Brazil that the intention was to seek to strengthen legislation and regulation on the impermissibility of child labour. To eliminate any possible ambiguity, the words “child labour and” could be replaced by “child labour as well as” in the proposed amendment to subparagraph 1(7) and a comma could be inserted between “children” and “employers” in the proposed amendment to subparagraph 1(11).

Dr BUSS (Brazil) requested time to consider those proposals.

Ms BILLINGS (Canada) expressed support for the draft resolution. She proposed that the fourth preambular paragraph should be amended by replacing the words “the safety and” with “in the” and by changing the position of Canada’s proposed amendment, so that the paragraph would read: “Acknowledging the responsibilities to ensure safety in the care and protection of children, affirmed in the Convention on the Rights of the Child (1989) and in International Labour Organization Convention 182 (199) and in the protection of persons with disabilities set out in the Convention on the Rights of Persons with Disabilities (2006), particularly in low- and middle-income countries where there exists a significant burden of child injuries”.

It was so agreed.

Dr REN Minghui (China) recalled that he had proposed that subparagraphs 1(5) and 1(7) be merged to produce the text set out in subparagraph 1(5bis). However, new amendments had been proposed to subparagraphs 1(5) and 1(7) and he therefore withdrew his proposal.

Dr PHILLIPS (adviser to Dr St John, Barbados), supporting the draft resolution, proposed that the fourth preambular paragraph should be amended further by replacing “low- and middle-income countries” with “developing, low- and middle-income countries”, since some of the vulnerable small island States were defined as having a high income.

Dr MOHAMED (Oman) supported the draft resolution but pointed out that there appeared to be an overlap between subparagraphs 2(2) and 2(6bis).

Following an exchange of views between Dr ALWAN (Assistant-Director General), Mr PHILLIPS (adviser to Dr St John, Barbados) and Dr MOHAMED (Oman), the CHAIRMAN suggested that paragraph 2(6bis) should be deleted.

It was so agreed.

Dr DAULAIRE (United States of America), referring to subparagraphs 1(7) and 1(11), agreed with the member for Brazil that the wording of his original amendment could be misinterpreted.

Instead of his previous wording, he proposed that in subparagraph 1(7) “on child labour and legal adolescent employment” should be replaced with “on the prevention of child labour, as well as on legal adolescent employment”.

Dr BUSS (Brazil) supported that proposal.

It was so agreed.

Mr DESIRAJU (adviser to Mr Chandramouli, India) pointed out that the Board should decide whether it wished to retain subparagraphs 1(10) and 1(10bis) or to replace them with the combined wording proposed in paragraph 1(10ter).

Ms BILLINGS (Canada) confirmed that paragraph 1(10ter) had been proposed by Canada as a means of combining the ideas contained in paragraphs 1(10) and 1(10bis).

The CHAIRMAN suggested that paragraph 1(10ter) should be retained and that paragraphs 1(10) and 1(10bis) should be deleted.

It was so agreed.

Dr BUSS (Brazil) proposed that a reference to International Labour Convention 138 concerning Minimum Age for Admission to Employment (1973) should be added to the fourth preambular paragraph, as it had been shown that setting a minimum age was an effective way of ensuring that children did not start work at too young an age.

It was so agreed.

The resolution, as amended, was adopted.¹

4. MATTERS FOR INFORMATION: Item 10 of the agenda (continued)

Progress reports: Item 10.2 of the Agenda (Documents EB128/35 and EB128/35 Add.1) (continued from the eleventh meeting, section 3)

F. Climate change and health (resolutions WHA61.19 and EB124.R5)

G. Improvement of health through sound management of obsolete pesticides and other obsolete chemicals (resolution WHA63.26)

H. Improvement of health through safe and environmentally sound waste management (resolution WHA63.25)

The CHAIRMAN invited the Board to consider the three progress reports relating to environmental issues that were contained in document EB128/35 Add.1, sections F, G and H.

Ms KOA-WING (adviser to Dr Gopee, Mauritius), speaking on behalf of the Member States of the African Region and referring to the progress report on improvement of health through safe and environmentally sound waste management, said that existing difficulties in managing waste in Africa were exacerbated by the illegal transboundary traffic in hazardous wastes. Moreover, the generally

¹ Resolution EB128.R15.

poor sanitation throughout Africa was aggravated by poor waste management practices, in particular the widespread dumping of wastes in bodies of water and uncontrolled dump sites. Although the use of the “polluter pays” principle was not yet commonplace, several countries had made progress in implementing safe and sound policies, strategies and projects. Producing biogas and compost from organic fractions of waste had been widely accepted as a best practice. Waste minimization, reuse and recycling were high on her country’s agenda.

The main challenge was to create sufficient capacity in Africa for environmentally sound management at a time of financial constraint and limited access to technical know-how. Another impediment was limited awareness of best practices for environmentally sound waste management. Furthermore, the fact that legislation in most parts of Africa assigned responsibility for waste management to municipalities, which were not properly equipped to deal with collection and disposal, impeded private-sector investment in such activities.

There were four lines of action: to urge Member States to use health impact assessments in waste management and ensure that it was safe and environmentally sound; to maintain support for implementation of the Bali Declaration on Waste Management for Human Health and Livelihood, to the extent allowed by WHO’s mandate and available resources; to work towards environmentally sound waste management with UNEP and the Secretariat of the Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and Their Disposal, including cooperation with governments and donor organizations; and to invite governments, relevant intergovernmental and regional economic integration organizations, industry and business entities, and civil society to provide resources and technical assistance to developing countries for the formulation and implementation of strategies and approaches to improve health through safe and environmentally sound waste management.

Dr TAKEI (adviser to Dr Omi, Japan), referring to the progress report on climate change and health, commended the collaboration on policy-making and implementation with intergovernmental schemes such as the Intergovernmental Panel on Climate Change. He encouraged good coordination within the Secretariat, especially among units dealing with infectious diseases, maternal and child health, and environmental health. He asked for the preliminary findings of the systematic review of recent research on climate change and health with regard to mitigation. Applied science was important, as was evident in the workplan endorsed in resolution EB124.R5. The Secretariat should continue to provide assistance for interdisciplinary research, for example on heat warning systems, the impact of climate change on natural disasters and related emergency preparedness and disease surveillance.

He commended WHO’s activities on improvement of health through sound management of obsolete pesticides and other obsolete chemicals in line with the Strategic Approach to International Chemicals Management. Management of waste and discarded pesticides had to be safe and environmentally friendly. Referring to asbestos control and the resolution concerning asbestos adopted in 2006 by the International Labour Conference at its 95th Session, he said that the Governments of Japan and Viet Nam were working with WHO and ILO to mitigate the adverse health effects of asbestos. Japan would continue to support asbestos control in collaboration with the relevant organizations.

Dr MAHFOUDI (adviser to Mr El Makkoui, Morocco) commended the Secretariat’s work on climate change and health and its support to Member States for the development of national and regional strategies and policies to mitigate the health effects of climate change. The impact of rising temperatures had been felt in the form of more frequent extreme weather events and other natural disasters. The weaknesses in current responses needed to be exposed, and all organizations working on climate change should formulate coordinated policies that would help Member States to assess risk factors and take the necessary measures to protect human health. He urged WHO to provide technical expertise and assistance in the follow-up to the United Nations Framework Convention on Climate Control and would welcome the establishment of a regional network to track diseases emerging as a result of climate change.

Dr GEDEON (Seychelles), speaking on behalf of the Member States of the African Region and referring to the progress report on improvement of health through sound management of obsolete pesticides and other obsolete chemicals, observed that the projected growth in the production and use of chemicals and the stockpiling of obsolete pesticides in the developing world were likely to cause more damage to health without sound chemicals management. Pesticide control was far from adequate in most African Member States.

Following the adoption of resolutions WHA63.25 and WHA63.26, the Secretariat had swiftly developed tools for the sound management of pesticides in order to reduce the associated health risks. Those tools were currently being used in selected countries in the African Region, and more countries would receive support to launch similar projects in the future. Much more time, effort and resources would be required to overcome obstacles in the areas of chemicals data management, management of chemical accidents and spills, enhancing knowledge of chemicals and their hazards, and promoting community awareness about chemicals management in general.

Dr OULD HORMA (Mauritania), speaking on behalf of the Member States of the African Region and referring to the progress report on climate change and health, said that several countries in the Region were experiencing climate-related emergencies – devastating floods and more frequent droughts such as that in the Sahel, which was resulting in increased malnutrition in several West African nations. Action was required not only to meet humanitarian needs, but also in the area of risk-reduction. As part of the efforts being made to implement the Libreville Declaration on Health and Environment in Africa, some countries were analysing their situations and assessing their needs. The resulting reports were providing input for the evaluation of climate change-related vulnerability. Other responses to the Libreville Declaration included a pilot project backed by the Global Environment Facility to test the strategies for health adaptation to climate change in seven countries.

The greatest challenge was the limited participation of the health sector in climate change negotiations, in particular with respect to the United Nations Framework Convention on Climate Change. Most countries in the Region had yet to designate focal points to work on climate and ensure proper coordination with environment ministries, in particular for the preparation, planning, implementation, follow-up and evaluation of a joint policy.

Professor AZAD (adviser to Professor Haque, Bangladesh), referring to the progress report on climate change and health, said that his country was extremely vulnerable to flooding related to climate change. Much bolder responses were needed. Bangladesh had developed a national climate-change strategy and action plan to build country capacity and increase its resilience; one of the six pillars therein covered food security, social protection and health. Several European donors had pledged funds to supplement the resources allocated by the Government to those endeavours. Climate change and health also formed part of the country's revised Poverty Reduction Strategy Paper and had been a prominent topic at the 2010 Bangladesh Development Forum.

With technical support from WHO, a health-vulnerability assessment had been undertaken in order to identify priorities, prepare adaptive measures, build health-sector capacity to address climate change, and enable Bangladesh to take a leadership position in global forums. The Ministry of Health and Family Welfare had established a dedicated unit on climate change and health promotion, and the forthcoming five-year plan for the health sector would address the impact of climate change on health.

WHO could facilitate collaboration between countries vulnerable to climate change on capacity building, research, prioritization, adaptation and resources mobilization. Intersectoral cooperation should also be enhanced. Resources were needed to strengthen the capacity of health systems to monitor and minimize the health impact of climate change. He drew attention to the Dhaka Declaration on South-East Asia Regional Health Concerns for Climate Change Negotiations, adopted by Member States of the South-East Asia Region in October 2010 and presented to the sixteenth Conference of the Parties to the United Nations Framework Convention on Climate Change.

Dr WATT (United Kingdom of Great Britain and Northern Ireland)¹ commended WHO's work on climate change, particularly that on health in a green economy, and expressed continued support for implementation of the Secretariat's workplan on climate change and health. The changing incidence of neglected tropical diseases and other communicable diseases as a result of climate change would have potentially serious consequences, and she emphasized the need for cross-departmental work on climate change and health. She urged the Secretariat to provide greater support to countries in developing and implementing adaptation plans, particularly the poorest and most vulnerable countries. Her Government would support the Secretariat in preparing for the seventeenth session of the Conference of the Parties to the United Nations Framework Convention on Climate Change.

Mr JERMAN (Slovenia),¹ referring to the progress report on improvement of health through sound management of obsolete pesticides and other obsolete chemicals, commended the Secretariat's work notably through the WHO Pesticides Evaluation Scheme and called for the extension of existing projects to other Member States. He further encouraged the Secretariat to strengthen its presence in, and increase activities under, the Strategic Approach to International Chemicals Management, particularly in preparing for the third session of the International Conference on Chemicals Management. He welcomed various developments in central and eastern Europe and the European Union since the adoption of resolution WHA63.26: the European Parliament had organized a hearing on obsolete chemicals; the countries of the Danube basin had begun work on a strategy that would include safe removal of obsolete pesticides and chemicals; Poland had assisted Armenia in constructing a facility for destruction of obsolete pesticides; and Ukraine had recently allocated almost €2 million to the destruction of hexachlorobenzene. Increased attention and resources were being devoted to the issue in the European Region, but much remained to be done. Additional financial support and more attention from donors were needed. WHO should contribute to efforts to eliminate and destroy obsolete chemicals, working with international partners, and should review the implementation of resolution WHA63.26 in the coming years.

Ms PAVALACHI-TISCIC (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN and referring to the progress report on climate change and health, welcomed WHO's participation in the sixteenth Conference of the Parties to the United Nations Framework Convention on Climate Change and encouraged the Director-General to attend the seventeenth Conference of the Parties in 2011, given the importance of high-level representation in drawing attention to the potentially serious health consequences of a failure to reach agreement on international action to combat climate change. Climate change would increase exposure to disease and threaten indigenous ways of life and the production of food, in some cases endangering people's very existence.

Dr NEIRA (Protection of the Human Environment) thanked speakers for their comments. With reference to climate change and health, she reaffirmed WHO's commitment to expanding its activities in relation to climate change and health across relevant departments within the Organization and with relevant organizations in the United Nations system. She welcomed the references that had been made to the Libreville and Dhaka declarations. Such regional declarations had been well received at the sixteenth Conference of the Parties to the United Nations Framework Convention on Climate Change in Cancún, Mexico, and had contributed to raising awareness of the need for technical support, assessment of vulnerability and workplans at country level. Additional resources were indeed required and she expressed appreciation to those Member States that had provided financial support. The Secretariat would explore the Global Environment Facility mechanisms with a view to providing support for adaptation to climate change to reduce its impact on health. As the Organization was also contributing to preparations for the seventeenth Conference of the Parties to the United Nations

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

Framework Convention on Climate Change, she welcomed the offer of support from the representative of the United Kingdom.

Referring to the progress reports on improvement of health through sound management of obsolete pesticides and other obsolete chemicals and on improvement of health through safe and environmentally sound waste management, she said that the Secretariat would work to fill the gaps in assessing the situation.

The DIRECTOR-GENERAL stressed that, in its work on climate change and health, WHO would focus on its core competencies, without, however, duplicating the work of the many other parties, both within and outside the United Nations system, that had major roles to play and contributions to make, for example in the areas of mitigation, adaptation, innovation – especially in green energy – and financing. Every effort should be made, as requested by Member States, to ensure an appropriate division of labour. WHO would have little contribution to make, for example, in the area of reduction of carbon dioxide emissions other than to provide guidance on the health effects of air pollution. The Organization would, however, augment its activities in relation to adaptation and she was therefore pleased to note the support for such a move expressed by the representative of the United Kingdom. She envisaged that, within the adaptation agenda, the Secretariat would provide support for countries such as Bangladesh in assessing their vulnerability to the effects of climate change and in strengthening their capacity for surveillance, preparedness and response, with an emphasis on the public health dimension, bearing in mind that extreme weather events clearly had an impact on disease patterns, especially for vector- and waterborne diseases, and on food supply.

- I. Working towards universal coverage of maternal, newborn and child health interventions (resolution WHA58.31)**
- J. Female genital mutilation (resolution WHA61.16)**
- K. Strategy for integrating gender analysis and actions into the work of WHO (WHA60.25)**

The CHAIRMAN invited the Board to consider the group of progress reports concerning maternal and child health and gender matters, contained in sections I, J and K of document EB128/35 Add.1.

Dr DAULAIRE (United States of America), noting the progress made in addressing the health needs of women and children and the appropriate priority accorded to the issue in the international community as a result of the United Nations Secretary General's Global Strategy for Women's and Children's Health, said that much work was still required to ensure that all women had adequate access to quality reproductive health services, such as family planning, pregnancy care, safe and attended childbirth, prevention and control of sexually transmitted infections, and protection from damaging and degrading practices such as female genital mutilation. He expressed concern at the increasing medicalization of female genital mutilation and stressed the role of all Member States in reducing the practice. He congratulated the Secretariat for the progress it had made in the area of gender analysis, which had served to highlight the important role of gender in many issues.

Ms BILLINGS (Canada), referring to the progress report on working towards universal coverage of maternal, newborn and child health interventions, welcomed WHO's commitment to monitoring the implementation of the United Nations Secretary General's Global Strategy for Women's and Children's Health and to reporting its findings at the Sixty-fourth World Health Assembly in May 2011. By launching the Muskoka Initiative, Canada had mobilized G8 Member States to set a global agenda for improving maternal, newborn and child health. Canada was keen to work with the Secretariat and the new Commission on Information and Accountability for Women's and Children's Health to develop a framework for global reporting, oversight and accountability in that area.

With regard to the progress report on female genital mutilation, she expressed strong support for WHO's efforts to stop the practice as it was a form of violence against women and girls and represented a severe violation of their human rights. The practice was illegal in Canada.

With regard to gender analysis, equality between men and women was an essential component of sustainable development, economic stability, social justice, peace and security. WHO must continue to advocate a broader perspective related to gender equality as a means of meeting global commitments such as the Millennium Development Goals and the United Nations Secretary General's Global Strategy on Women's and Children's Health. She encouraged the Secretariat to continue its efforts to implement its gender equality strategy within its programmes and activities, in particular with regard to strengthening its capacity for mainstreaming gender issues. She noted with concern the decrease in the number of women employed in the national professional officer category and the continued under-representation of women at higher professional grade levels. WHO should continue to proceed with its work in that area as part of its reform process.

Dr OULD HORMA (Mauritania), speaking on behalf of the Member States of the African Region, said that female genital mutilation was a firmly entrenched traditional practice. In all its forms, and particularly type III, the most severe form, it had serious consequences for the health of teenage and adult women. In Africa, an estimated 90 million girls and women had undergone the practice and at least another three million were at risk of being subjected to it every year. According to a mid-term evaluation in 12 countries, all had adopted legislation against the practice and national committees to eliminate it had been set up in cooperation with United Nations bodies and local and international nongovernmental organizations. Countries were engaging in information campaigns, educational activities and community-based actions, and guidelines for eliminating the practice were being formulated and promoted. Long-term investment was needed for its elimination, but owing to the proliferation of pressing problems and lack of resources, governments were still not providing the requisite funding. Currently, financing depended primarily on development partners.

Professor AZAD (adviser to Professor Haque, Bangladesh) welcomed WHO's initiatives on improving maternal, newborn and child health with a view to achieving Millennium Development Goals 4 and 5. Although less progress had been made towards Goal 5 than other Goals, the United Nations Summit on the Millennium Development Goals (New York, 20–22 September 2010) and the launch by the United Nations Secretary General of the Global Strategy on Women's and Children's Health had provided powerful impetus for accelerating actions towards reducing maternal mortality rates. The joint "Health 4 + 1" initiative between UNICEF, UNFPA, WHO, the World Bank and UNAIDS had been providing support for further action in countries that so required, including three countries in the South-East Asia Region (Bangladesh, India and Nepal).

Reproductive health-care services in Bangladesh were provided throughout the health system, in both health-care facilities and households through domiciliary health staff. Significant progress had been made in survival rates of infants and children under the age of five years, and the Prime Minister had recently received an United Nations Millennium Development Goal Award 2010 for progress towards Millennium Development Goal 4. In the area of maternal and child health, gaps existed in the continuum of care, particularly in the postnatal period when the risk of mortality was high for both the mother and the newborn infant. Efforts to promote institutional delivery and to monitor newborn babies closely in the first few days of life should help to reduce the child mortality rate drastically. The shortage of health workers, especially obstetricians, anaesthetists and skilled birth attendants, seriously hampered expansion of such efforts but the Ministry of Health and Family Welfare had introduced a community health-clinic programme, which provided a range of preventive and curative health care services and was based on a philosophy of community ownership. The opening of thousands of new clinics and health centres should contribute significantly to broadening access to primary health care and therefore improving maternal, neonatal and child health. The training, deployment and retention of skilled care workers close to the community were crucial to ensuring universal coverage of maternal, newborn and child health interventions, and the Secretariat's support in that respect was extremely important for developing countries. The Secretariat should use the current momentum and interest at

the highest level with respect to Goal 5 in order to advance work with Member States to advocate an increase in resources for maternal, newborn and child health and to strengthen the multisectoral approach to tackling barriers to access.

Dr TAKEI (adviser to Dr Omi, Japan) said that many interventions to promote universal coverage of maternal, newborn and child health did not have a lasting effect without proper coordination. Evidence-based and effective programmes focusing on country ownership and financial backing by the recipient countries needed to be planned and implemented. Other important issues related to the quality and the continuum of care. Indicators were necessary to measure improvements in the quality of care, but setting them was not enough: bottlenecks and other obstacles needed to be identified and eliminated systematically.

Japan recognized the importance of strengthening support to African countries to eliminate female genital mutilation. Although some progress was apparently being made, it was slow, especially as only four countries had announced action plans on the practice. It was especially regrettable when female genital mutilation was carried out by medical staff, who should contribute to health, not damage it; he supported the remarks of the member for the United States in that regard. The Secretariat should continue to play a role in eliminating female genital mutilation.

Dr IBRAHIM (Somalia) said that female genital mutilation had no benefits, only immediate and long-term harmful consequences for girls and women. Women who had undergone the practice were significantly more likely to experience complications in childbirth and higher prenatal mortality rates for their babies. It put three million women at risk in 28 African countries every year, and the practice had also been documented in the Middle East, Asia and South America. It was internationally recognized as a human rights violation, and laws criminalizing it had been introduced in 20 African countries and several countries in the Eastern Mediterranean Region. Thirteen countries receiving immigrants from countries where female genital mutilation was practised had also legislated against it.

Despite the international community's stepped-up efforts to eliminate the practice in past decades, the rate of progress towards a significant decline was slow, with global efforts undermined by the limited implementation of laws and strong religious and cultural beliefs. Nevertheless, community action by nongovernmental organizations, governments and religious leaders in many countries had resulted in hundreds of communities publicly declaring their intent to discontinue the practice. All regional offices in regions where the practice was prevalent were engaged in, and should intensify, activities to eliminate it. The countries concerned needed to put in place appropriate policies and laws, and were in urgent need of the Secretariat's technical support to that end.

Dr DE ASSUNÇÃO OSWALDO SAÍDE (Mozambique), speaking on behalf of the Member States of the African Region and referring to the progress report on working towards universal coverage of maternal, newborn and child health interventions, said that maternal mortality ratios remained high across the Region but the under-five mortality rate had fallen from 180 to 142 per 1000 live births between 1990 and 2008. Child mortality was declining by an average of 1.4 % per year.

In order to address the unacceptable levels of maternal and newborn mortality in sub-Saharan Africa, health ministers of the African Region had agreed on ways to make faster progress towards the relevant Millennium Development Goals: providing skilled attendance during pregnancy, childbirth and the postpartum period at all levels of the health-care delivery system; and strengthening the capacity of individuals, families and communities to improve maternal, newborn and child health. In addition, more than 15 countries in the Region had launched the Campaign on Accelerated Reduction of Maternal Mortality in Africa. The number of countries implementing the Integrated Management of Childhood Illness strategy in more than 75% of districts had increased to 22 from 10 in 2007.

The major challenges to maternal, newborn and child health in the African Region included: inadequate access to high-quality health care for children and women; inadequate legislation for the protection of women and children, including laws against gender-based violence; sexually transmitted

infections, including HIV; cervical cancer; harmful practices and violence against women and children; and sexual and reproductive health problems affecting young people.

Dr AL BITTAR (adviser to Dr Said, Syrian Arab Republic), also referring to the progress report on working towards universal coverage of maternal, newborn and child health interventions, said that reducing maternal and infant mortality would reflect not only improvements in health indicators per se but also the fact that political commitment to achieve those improvements existed.

Female genital mutilation was not practised in his country, where equal rights had been accorded to women since the beginning of the twentieth century. He acknowledged the severity of the problem, which caused physical and psychological trauma.

Mrs HANJAM DA COSTA SOARES (Timor-Leste), speaking on behalf of the Member States of the South-East Asia Region, welcomed the progress report on working towards universal coverage of maternal, newborn and child health interventions. Her country, despite its strong political commitment to improving the situation, still had high rates of maternal and newborn mortality, and needed considerable strong support from WHO and other organizations in the United Nations system to achieve Millennium Development Goals 4 and 5.

Dr WATT (United Kingdom of Great Britain and Northern Ireland)¹ underlined the priority her Government attached to expanding critical interventions to save the lives of women and children, including greater access to skilled birth attendants and family planning, and to improving quality of care. It supported the United Nations Secretary General's Global Strategy for Women's and Children's Health. The Government had published a framework for results on reproductive, maternal and newborn health on 31 December 2010 and looked forward to continuing to work with the Secretariat and other partners in order to ensure accountability for the delivery of all commitments.

Dr BUSTREO (Assistant Director-General), responding to comments made on the progress report on working towards universal coverage of maternal, newborn and child health interventions, noted the concerns raised by several speakers on continuum of care coverage, particularly postnatal care in the week after birth, and the still unmet and increasing need for family planning. She welcomed the continued commitment to deal with those matters and reiterated the Secretariat's willingness to provide support to countries through strategies to expand coverage and to deliver the necessary information and evidence. The report did not detail the work in which WHO was actively engaged with other organizations in the United Nations system through the "Health 4 + 1" initiative to provide support to countries that had made efforts to expand coverage. Responding to comments on the need for skilled birth attendants, she noted the increasing emphasis on human resources. The Secretariat was working closely with partners to produce a report on midwifery, the draft of which would be available at the next Health Assembly.

She reiterated WHO's commitment to halting the medicalization of the practice of female genital mutilation as it breached both the medical professionalism and ethical responsibilities of those who carried it out and wrongly gave a sense of legitimacy to the practice besides violating national laws. The Secretariat would continue to work on global strategies to prevent medicalization of the practice.

Considerable progress on integrating gender analysis and actions into the work of WHO was likely in the coming year, particularly as a result of the recently established Commission on Information and Accountability for Women's and Children's Health, some of whose work would focus on analysis of data and disaggregation by gender and age group.

The creation the previous year of the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) represented a significant step forward in analysing the work

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

not just of WHO but of all other organizations in the United Nations system and how they approached gender disaggregated data and policies with a view to improving women's health and social conditions.

The Board took note of the progress reports in document EB128/35 Add.1.

Provisional agenda of the Executive Board at its 129th session

Dr JESSE (Estonia) said that, in reviewing jointly with Germany and Norway the informal background paper on reporting requirements for governing body agenda items and the summary tables¹ that Board members had received the previous week, she had noted the high number of items for which annual or biennial reporting was required. It was evident that, over time, the consequent burden of reporting on the Secretariat had grown considerably. The notes to the background paper indicated the possibility of identifying inconsistencies or areas of overlap that could usefully be corrected, with a view to efficient planning of agendas and more effective use of time of the governing bodies. Therefore, she proposed that the provisional agenda of the Board at its 129th session should include an item on reporting requirements. In order to facilitate those discussions, she requested the Secretariat to propose ways in which inconsistencies and overlaps could be eliminated and how to facilitate more efficient and outcome-oriented reporting in the future.

The DIRECTOR-GENERAL expressed her appreciation for those comments, given the importance of effective governance. Discussions on WHO's internal governance mechanisms were extremely important and she welcomed further guidance thereon from Board members in the future. The Secretariat would contribute to all discussions on that subject if the Board decided to consider it at its next session.

The CHAIRMAN took it that the Board wished to accept the request to include an item on reporting requirements for governing body items in the provisional agenda of the Executive Board at its 129th session.

It was so agreed.

5. MANAGEMENT MATTERS: Item 8 of the Agenda (resumed)

Reports of committees of the Executive Board: Item 8.2 of the Agenda

- **Standing Committee on Nongovernmental Organizations** (Documents EB128/28 and EB18/28 Add.1)

Dr GEDEON (Seychelles), speaking on behalf of Professor Haque (Bangladesh), the Chairman of the Standing Committee on Nongovernmental Organizations, presented the Committee's report (document EB128/28) and drew particular attention to section III, which contained the Committee's recommendations in the form of a draft resolution and a draft decision for consideration by the Board. He expressed the Committee's appreciation of the work of the applicant organizations and those whose activities had been reviewed.

¹ Document WHO/DGO/GBS/11.1.

The CHAIRMAN invited Board members to consider the draft resolution and draft decision contained in EB128/28.

The resolution and decision were adopted.¹

- **Foundations and awards** (Document EB128/29)

Dr A.T. Sousha Foundation Prize

Decision: The Executive Board, having considered the report of the Dr A.T. Sousha Foundation Committee, awarded the Dr A.T. Sousha Foundation Prize for 2011 to Professor Amjad Daoud Niazi (Iraq). The laureate will receive 2500 Swiss francs.²

Ihsan Doğramacı Family Health Foundation Prize

The CHAIRMAN, noting that the Ihsan Doğramacı Family Health Selection Panel had met on 18 January 2011 under his chairmanship, said that, following a thorough discussion, the Panel had concluded that it was not in a position to propose a candidate for the Prize in 2011.

Sasakawa Health Prize

Decision: The Executive Board, having considered the report of the Sasakawa Health Prize Selection Panel, awarded the Sasakawa Health Prize for 2011 jointly to Dr Eva Siracká (Slovakia) and the Fraternidad Pequeña Familia de María – Albergue de María (Panama) for their outstanding innovative work in health development. The laureates will receive US\$ 30 000 and US\$ 40 000 respectively.³

United Arab Emirates Health Foundation Prize

Decision: The Executive Board, having considered the report of the United Arab Emirates Health Foundation Selection Panel, awarded the United Arab Emirates Health Foundation Prize for 2011 jointly to Aged Care Maldives (Maldives) and the Association Tchadienne Communauté pour le Progrès (Chad) for their outstanding contributions to health development. The laureates will each receive US\$ 20 000.⁴

State of Kuwait Prize for Research in Health Promotion

Decision: The Executive Board, having considered the report of the State of Kuwait Health Promotion Foundation Selection Panel, awarded the State of Kuwait Prize for Research in Health Promotion jointly to Mr Wang Dechen, Director of the Institute of Health Education, Ningxia Hui Autonomous Region, China, and to the Association Tchadienne Communauté pour le Progrès (Chad) for their outstanding contributions to research in health promotion. The laureates will each receive US\$ 20 000.⁵

¹ Resolution EB128.R16 and decision EB128(1).

² Decision EB128(2).

³ Decision EB128(3).

⁴ Decision EB128(4).

⁵ Decision EB128(5).

Dr LEE Jong-wook Memorial Prize for Public Health

Decision: The Executive Board, having considered the report of the Dr LEE Jong-wook Memorial Prize Selection Panel, awarded the Dr LEE Jong-wook Memorial Prize for Public Health for 2011 to the Clodomiro Picado Institute (Costa Rica) for its outstanding contribution to the control of neglected tropical diseases. The laureate will receive US\$ 85 000.¹

The CHAIRMAN said that the Panel had unanimously decided to propose to the Executive Board that Articles 2 to 4 of the Statutes of the Dr LEE Jong-wook Memorial Prize for Public Health be amended in order to take into account a change in the name of the Founder, to increase the amount of the Prize from US\$ 85 000 to US\$ 100 000 and modify the annual endowment referred to in Article 3 of the Statutes accordingly, and to extend the purpose of the Prize by providing that it would reward outstanding contributions to public health.

He took it that the Board wished to approve the changes proposed to the Statutes.

It was so decided.²

Provisional agenda of the Sixty-fourth World Health Assembly and date and place of the 129th session of the Executive Board: Item 8.3 of the Agenda (Document EB128/30 Rev.1)

Mrs ROSE-ODUYEMI (Office of the Governing Bodies) said that the Secretariat had noted one amendment to the draft provisional agenda of the Sixty-fourth World Health Assembly contained in the report, namely that a new item “Election of the Director-General of the World Health Organization” would be included.

The CHAIRMAN invited comments from the Board on the draft decision contained in paragraph 4 of document EB128/30 Rev.1.

Dr MÉSZAROS (adviser to Dr Kökény, Hungary), requested information from the Secretariat on the proposed item 13.16, on youth and health risks.

Mrs ROSE-ODUYEMI (Office of the Governing Bodies) said that the item had been proposed by the Minister of Health of Tunisia both during his statement as President of the Sixty-third World Health Assembly and formally in writing to the Secretariat, in accordance with Rule 5 of the Rules of Procedure of the World Health Assembly.

The CHAIRMAN asked, in light of the comments made by the member for Hungary, for comments on item 13.16 on youth and health risks.

Dr MOHAMED (Oman) said that much of the agenda had particular relevance to adolescents and young people and said that the request to include the item should be upheld.

The CHAIRMAN took it that the Board wished to approve the provisional agenda, as amended.

It was so decided.¹

¹ Decision EB128(6).

² Decision EB128(7).

The CHAIRMAN recalled that Mr Yusof had replaced Dr Osman as the Board member designated by Brunei Darussalam, and that, following consultations among Board members in the Western Pacific Region, it had been proposed that Mr Yusof should also replace Dr Osman as a Vice-Chairman of the Board. He therefore further proposed that, in that capacity, Mr Yusof should also replace Dr Osman as the Board's representative at the Sixty-fourth World Health Assembly. Decision EB127(7) would have to be revised accordingly. In the absence of any objection, he would take it that the Board wished to approve that step.

It was so decided.²

The CHAIRMAN proposed that the 129th session of the Executive Board, following the Sixty-fourth World Health Assembly, should be held on 25 May 2011, lasting one day.

It was so decided.³

The CHAIRMAN said that, in compliance with Rule 8 of the Rules of Procedure of the Executive Board, the provisional agenda for the 129th session of the Board would be drawn up by the Director-General and circulated to Member States and Associate Members within four weeks of the closure of the current session.

The meeting rose at 12:05.

¹ Decision EB128(8).

² Decision EB128(9).

³ Decision EB128(10).

THIRTEENTH MEETING

Monday, 24 January 2011, at 14:40

Chairman: Dr M. KÖKÉNY (Hungary)

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

Prevention and control of noncommunicable diseases: Item 4.14 of the Agenda (continued from the tenth meeting) (Document EB128/17)

The CHAIRMAN, reporting on the results of informal consultations held after the previous meeting, said that, despite the goodwill and noble intentions of all parties, it had not been possible to reach consensus on the draft resolution on WHO's role in the preparation, implementation and follow-up to the high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases (September 2011). The Board would report on the status of its discussions, during which much progress had been made, to the Sixty-fourth World Health Assembly. All the amendments that had already been proposed would be incorporated in a revised text which, it was to be hoped, would facilitate discussion and enable the Health Assembly to reach consensus. In addition, Member States were invited to submit new amendments to the Secretariat before 15 February 2011.

He took it that the Board endorsed that approach.

It was so agreed.

Ms BILLINGS (Canada) said that one reason she had not been able to approve the draft resolution was because it had been circulated late in the Board's proceedings. She invited the Secretariat to consider how to improve the Board's operations by expediting the issuance of documentation, in conformity with the governance rules that already existed, or by filling in any gaps in those rules.

The CHAIRMAN said that due note would be taken of those observations.

2. CLOSURE OF THE SESSION: Item 11 of the Agenda

The DIRECTOR-GENERAL said that, despite a heavy agenda, the Board had completed its work on time, thanks to the effective management of its Chairman and the cooperation of Board members. Board members had disagreed, sometimes sharply, but they had always shown a collaborative spirit and willingness to compromise. The fact that they had reached agreement on so many potentially divisive issues was indicative of their strong desire for progress in the health field.

The Programme, Budget and Administration Committee's work had greatly facilitated the budgetary discussions. She undertook to carry out the Board's wish to move from an aspirational to a more realistic budget.

The Board would be forwarding to the Sixty-fourth World Health Assembly several resolutions that had been made as clear and balanced as possible. The resolutions underlined the importance attached by Member States to the strengthening of health systems, noncommunicable diseases and the

preparations for the high-level meeting of the United Nations General Assembly in September 2011, including the First Global Ministerial Conference in Moscow.

She confirmed her commitment and that of the regional directors to the process of change that had been launched during the session. Board members had been unanimous in their support for far-reaching, evolutionary reforms. There was agreement on the need to move quickly but carefully and in close consultation with, among others, independent experts who could provide guidance on preparing a professional, objective and transparent agenda for reform. The governing bodies, the Organization's shareholders and ultimate arbiters, would also be consulted. She had listened closely to the views of Board members. There was hard work ahead, but she found the opportunity for change invigorating and the potential for a more efficient and effective WHO entirely worth the effort.

The CHAIRMAN recalled that he had predicted that the current Board session would be exciting and challenging. Board members had grappled with complex issues ranging from finance and management to a broad array of technical and health matters, investing much time and effort into forging consensus on many important questions. A spirit of mutual understanding had prevailed, permitting a strong commitment to public health to overcome vested interests. As a result, important decisions had been made and advice provided to help to facilitate the work of WHO. The Director-General had received support for undertaking a major reform to make the Organization fit for purpose. Such reform would help to define more clearly and strengthen WHO's leadership role in global health governance, which was crucial in the light of complex global public health challenges.

WHO had set sail on a quest towards achieving the Millennium Development Goals, universal coverage and success in the fight against noncommunicable diseases. Members had committed themselves to assist the Director-General as she navigated towards those goals. They had charted the course for the next two years by setting priorities in public health and managerial reform. All would like to see a stronger, more transparent and more knowledge-based WHO. During the current session, progress had been made in that direction.

He declared the 128th session closed.

The meeting rose at 15:10.
